

Internal Revenue bulletin

Bulletin No. 2010-43
October 25, 2010

HIGHLIGHTS OF THIS ISSUE

These synopses are intended only as aids to the reader in identifying the subject matter covered. They may not be relied upon as authoritative interpretations.

INCOME TAX

T.D. 9495, page 477.

Final regulations under section 1397E of the Code provide guidance to issuers that issued qualified zone academy bonds (QZABs) on or before October 3, 2008, relating to expenditures of bond proceeds, arbitrage, information reporting, remedial actions for situations when QZAB proceeds are not used for a qualified purpose, and certain other miscellaneous rules.

T.D. 9496, page 484.

Final regulations under section 6050W of the Code relate to information reporting requirements, information reporting penalties, and backup withholding requirements for payment card and third party network transactions.

Notice 2010-67, page 529.

This notice provides transitional relief from the information reporting requirements in section 6045A of the Code that apply to transfers of securities by brokers and other custodians.

EMPLOYEE PLANS

T.D. 9494, page 500.

REG-125592-10, page 556.

Final, temporary, and proposed regulations under section 9815 of the Code provide guidance concerning the requirements for internal claims and appeals and external review processes for group health plans and health insurance issuers under the Affordable Care Act.

EXCISE TAX

T.D. 9494, page 500.

REG-125592-10, page 556.

Final, temporary, and proposed regulations under section 9815 of the Code provide guidance concerning the requirements for internal claims and appeals and external review processes for group health plans and health insurance issuers under the Affordable Care Act.

ADMINISTRATIVE

T.D. 9496, page 484.

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Notice 2010-67, page 529.

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Rev. Proc. 2010-38, page 530.

This procedure contains the latest revision of Publication 1516, *Specifications for Filing Form 8596, Information Return for Federal Contracts, Electronically*. Rev. Proc. 2008-49 superseded.

Announcement 2010-87, page 557.

This announcement contains updates to all publications associated with filing information returns through the Filing Information Returns Electronically (FIRE) System.

Finding Lists begin on page ii.
Index for July through October begins on page iv.



Department of the Treasury
Internal Revenue Service

The IRS Mission

Provide America's taxpayers top-quality service by helping them understand and meet their tax responsibilities and en-

force the law with integrity and fairness to all.

Introduction

The Internal Revenue Bulletin is the authoritative instrument of the Commissioner of Internal Revenue for announcing official rulings and procedures of the Internal Revenue Service and for publishing Treasury Decisions, Executive Orders, Tax Conventions, legislation, court decisions, and other items of general interest. It is published weekly and may be obtained from the Superintendent of Documents on a subscription basis. Bulletin contents are compiled semiannually into Cumulative Bulletins, which are sold on a single-copy basis.

It is the policy of the Service to publish in the Bulletin all substantive rulings necessary to promote a uniform application of the tax laws, including all rulings that supersede, revoke, modify, or amend any of those previously published in the Bulletin. All published rulings apply retroactively unless otherwise indicated. Procedures relating solely to matters of internal management are not published; however, statements of internal practices and procedures that affect the rights and duties of taxpayers are published.

Revenue rulings represent the conclusions of the Service on the application of the law to the pivotal facts stated in the revenue ruling. In those based on positions taken in rulings to taxpayers or technical advice to Service field offices, identifying details and information of a confidential nature are deleted to prevent unwarranted invasions of privacy and to comply with statutory requirements.

Rulings and procedures reported in the Bulletin do not have the force and effect of Treasury Department Regulations, but they may be used as precedents. Unpublished rulings will not be relied on, used, or cited as precedents by Service personnel in the disposition of other cases. In applying published rulings and procedures, the effect of subsequent legislation, regulations,

court decisions, rulings, and procedures must be considered, and Service personnel and others concerned are cautioned against reaching the same conclusions in other cases unless the facts and circumstances are substantially the same.

The Bulletin is divided into four parts as follows:

Part I.—1986 Code.

This part includes rulings and decisions based on provisions of the Internal Revenue Code of 1986.

Part II.—Treaties and Tax Legislation.

This part is divided into two subparts as follows: Subpart A, Tax Conventions and Other Related Items, and Subpart B, Legislation and Related Committee Reports.

Part III.—Administrative, Procedural, and Miscellaneous.

To the extent practicable, pertinent cross references to these subjects are contained in the other Parts and Subparts. Also included in this part are Bank Secrecy Act Administrative Rulings. Bank Secrecy Act Administrative Rulings are issued by the Department of the Treasury's Office of the Assistant Secretary (Enforcement).

Part IV.—Items of General Interest.

This part includes notices of proposed rulemakings, disbarment and suspension lists, and announcements.

The last Bulletin for each month includes a cumulative index for the matters published during the preceding months. These monthly indexes are cumulated on a semiannual basis, and are published in the last Bulletin of each semiannual period.

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Part I. Rulings and Decisions Under the Internal Revenue Code of 1986

Section 1397E.—Credit to Holders of Qualified Zone Academy Bonds

26 CFR 1.1397E-1: *Qualified Zone Academy Bonds.*

T.D. 9495

DEPARTMENT OF THE TREASURY Internal Revenue Service 26 CFR Parts 1 and 602

Qualified Zone Academy Bonds; Obligations of States and Political Subdivisions

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Final regulations and removal of temporary regulations.

SUMMARY: This document removes the temporary regulations and provides final regulations that provide guidance to state and local governments that issue qualified zone academy bonds and to banks, insurance companies, and other taxpayers that hold those bonds on the program requirements for qualified zone academy bonds. The final regulations implement the amendments to section 1397E (discussed in this preamble) and provide guidance on the maximum term, permissible use of proceeds, and remedial actions for qualified zone academy bonds.

DATES: *Effective Date:* These regulations are effective on July 30, 2010.

Applicability Date: For dates of applicability, see §1.1397E-1(m) of these regulations.

FOR FURTHER INFORMATION CONTACT: Zoran Stojanovic, (202) 622-3980 (not a toll-free number).

SUPPLEMENTARY INFORMATION:

Paperwork Reduction Act

The collection of information contained in these final regulations has been reviewed and approved by the Office of

Management and Budget in accordance with the Paperwork Reduction Act of 1995 (44 U.S.C. 3507(d)) under control number 1545-1908. This information will be used to identify issuers of qualified zone academy bonds that have established a defeasance escrow as a remedial action taken because of failure to satisfy certain requirements of section 1397E.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid control number.

Books and records relating to a collection of information must be retained as long as their contents may become material in the administration of any internal revenue law. Generally, tax returns and tax return information are confidential, as required by 26 U.S.C. 6103.

Background

Section 1397E(a) of the Internal Revenue Code (Code) provides that an eligible taxpayer (within the meaning of section 1397E(d)(6)) that holds a qualified zone academy bond (“QZAB” or “QZABs”) on a credit allowance date is allowed a credit against Federal income tax for the taxable year that includes the credit allowance date. In general, a QZAB is a bond issued by a state or local government to finance certain eligible public school purposes under section 1397E(d). Section 1397E(b) provides that the amount of the QZAB credit equals the product of the credit rate and the face amount of the bond held by the taxpayer on the credit allowance date. Under section 1397E(b)(2), the credit rate is determined by the Treasury Department and equals the percentage that the Department estimates generally will permit the issuance of QZABs without discount and without interest cost to the issuer. Section 1397E(i)(1) defines *credit allowance date* as the last day of the one-year period beginning on the issue date of the issue and the last day of each successive one-year period thereafter. Under section 1397E(d)(3), the maximum term of a QZAB is determined by the Treasury Department and equals the term

that the Department estimates will result in the present value of the obligation to repay the principal on the bond being equal to 50 percent of the face amount of the bond.

Section 1397E(j) provides that the amount of the QZAB credit allowed to the taxpayer is included in the taxpayer’s gross income.

Section 1397E(e) imposes a national limitation on the amount of QZABs that may be issued for each calendar year. The limitation is allocated by the Treasury Department among the States on the basis of their respective populations of individuals below the poverty line.

Section 1397E was amended by section 107 of the Tax Relief and Health Care Act of 2006, Public Law 109-432, 120 Stat. 2922 (2006) (the “2006 Act”), by adding certain requirements for a bond to be a QZAB. In general, the 2006 Act added a new five-year spending period requirement, arbitrage investment restrictions, and information reporting requirements. Specifically, the 2006 Act added new section 1397E(f), which generally imposes spending period restrictions under which an issuer of QZABs must reasonably expect, as of the issue date, that: (1) at least 95 percent of the proceeds from the sale of the issue are to be spent for one or more qualified purposes with respect to qualified zone academies within the 5-year period beginning on the issue date of the QZAB; (2) a binding commitment with a third party to spend at least 10 percent of the proceeds from the sale of the issue will be incurred within the six-month period beginning on the issue date of the QZAB; and (3) such purposes will be completed with due diligence and the proceeds from the sale of the issue will be spent with due diligence. New section 1397E(f)(2) added by the 2006 Act provides authority to the Secretary of the Treasury to extend the five-year spending period. To the extent that less than 95 percent of the proceeds of the issue are spent within the five-year spending period (plus any extension granted by the Secretary of the Treasury), the 2006 Act requires the issuer to redeem the nonqualified bonds within 90 days after the end of such period.

In addition, the 2006 Act added new section 1397E(g), which generally requires that an issue of QZABs satisfy the arbitrage investment restrictions of section 148 with respect to the proceeds of the issue.

Finally, the 2006 Act added new section 1397E(h), which generally requires that issuers of QZABs submit information reporting returns to the IRS similar to the information reporting returns required to be submitted to the IRS under section 149(e) for tax-exempt state or local bonds.

Section 15316 of the Food, Conservation, and Energy Act of 2008, Public Law 110–246, 122 Stat. 1651 (2008) (the “2008 Energy Act”), added section 54A to the Code. Section 54A(a) provides that a taxpayer that holds a qualified tax credit bond on one or more credit allowance dates of the bond occurring during any taxable year is allowed as a credit against Federal income tax for the taxable year an amount equal to the sum of the credits determined under section 54A(b) with respect to such dates. Section 54A(d)(1) provides that the term *qualified tax credit bond* (“QTCB”) means a certain bond which is part of an issue that meets the requirements of section 54A(d)(2), (3), (4), (5), and (6) regarding expenditures of bond proceeds, information reporting, arbitrage, maturity limitations, and prohibitions against financial conflicts of interest. At the time of its enactment, the 2008 Energy Act did not treat QZABs as QTCBs.

Section 313 of the Tax Extenders and Alternative Minimum Tax Relief Act of 2008, Div. C of Public Law 110–343, 122 Stat. 3765 (2008) (the “2008 Act”) added new section 1397E(m) providing that section 1397E shall not apply to any obligation issued after the date of the enactment of the 2008 Act on October 3, 2008. Effective for obligations issued after October 3, 2008, the 2008 Act amended section 54A(d)(1) defining a QTCB to include a qualified zone academy bond under section 54E of the Code. The 2008 Act also added section 54E, which provides revised program provisions for QZABs in lieu of the existing provisions under section 1397E and amended section 54A(d)(2)(C) to provide that, for purposes of section 54A(d)(2), the term “qualified purpose” for a QZAB means a purpose specified in section 54E(a)(1).

Section 301 of the Hiring Incentives to Restore Employment Act, Public Law No. 111–147, 124 Stat. 71 (2010) (the “HIRE Act”) added subsection (f) to section 6431 of the Code, which authorizes issuers to elect irrevocably to receive Federal direct payments of allowances of refundable tax credits to subsidize a prescribed portion of their borrowing costs instead of the Federal tax credits that otherwise would be allowed to holders of certain qualified tax credit bonds under section 54A. Under section 6431(f)(3)(A)(iii), the direct payment subsidy option under section 6431(f) applies to qualified zone academy bonds issued under section 54E that meet the requirements to be qualified tax credit bonds under section 54A.

Temporary regulations (T.D. 8755, 1998–1 C.B. 653) interpreting section 1397E were published on January 7, 1998 (63 FR 671), and amended on July 1, 1999 (T.D. 8826, 1999–2 C.B. 107 [64 FR 35573]). Final regulations under section 1397E (T.D. 8903, 2000–2 C.B. 352) were published on September 26, 2000 (65 FR 57732) (the “First Final Regulations”). On March 26, 2004, a notice of proposed rulemaking (REG–121475–03, 2004–1 C.B. 793) was published in the **Federal Register** (69 FR 15747) (the “2004 Proposed Regulations”). The 2004 Proposed Regulations proposed to amend the First Final Regulations by providing guidance on the maximum term, permissible use of proceeds, and remedial actions for QZABs. A public hearing was scheduled for July 21, 2004. The public hearing was cancelled because no requests to speak were received. Written comments on the 2004 Proposed Regulations were received. After consideration of the written comments, and in light of the statutory changes made by the 2006 Act, the need for regulatory guidance on those statutory changes, and the close connection between that needed guidance and the guidance in the 2004 Proposed Regulations, the IRS and the Treasury Department determined to issue coordinated guidance as temporary regulations under T.D. 9339, 2007–2 C.B. 437, which were published in the **Federal Register** on July 16, 2007 (72 FR 38767) and which became effective as of September 14, 2007 (the “Temporary Regulations”), with an opportunity for public comment in the corresponding

proposed regulations (the “2007 Proposed Regulations”). The 2004 Proposed Regulations were withdrawn. No public hearing was requested and no written comments were received pursuant to the 2007 Proposed Regulations.

Accordingly, the IRS and the Treasury Department adopt the 2007 Proposed Regulations, in substantially the same form as the 2007 Proposed Regulations, as final regulations by this Treasury Decision.

Effective/Applicability Dates

In general, except as otherwise provided, these final regulations generally apply to QZABs issued under section 1397E that are sold on or after September 14, 2007.

Pursuant to section 313(b) of the 2008 Act, effective for QZABs that are sold after October 3, 2008, section 1397E is inapplicable and successor modified statutory provisions for QZABs apply under sections 54A and 54E. These final regulations generally do not apply to QZABs issued under sections 54A and 54E. However, Notice 2009–30, 2009–16 I.R.B. 852 (April 20, 2009) and Notice 2010–22, 2010–10 I.R.B. 435 (March 8, 2010) (relating to 2009 and 2010 volume cap allocations for QZABs respectively), provide that for QZABs issued under sections 54A and 54E that are sold on or after October 4, 2008, pending the promulgation and effective date of future administrative or regulatory guidance, taxpayers may rely on the interim guidance provided in these notices and, to the extent not inconsistent with these notices and the provisions of sections 54A and 54E, the Temporary Regulations issued under section 1397E. See §601.601 (d)(2)(ii)(b).

The final regulations include a limited reliance provision for QZABs issued under sections 54A and 54E. Under this reliance provision, except to the extent inconsistent with the successor statutory provisions for QZABs in sections 54A and 54E and public administrative or regulatory guidance under those provisions and except as otherwise provided in a special restriction against reliance on the remedial action provisions in the final regulations, issuers and taxpayers may rely on the final regulations for QZABs that are issued under sections 54A and 54E. In the case of QZABs that are issued under sections

54A and 54E for which the issuer elects the Federal direct payment subsidy option under section 6431(f), issuers and taxpayers may not rely on the remedial action provisions in §1.1397E-1(h) of the final regulations. The IRS and Treasury Department expect to announce appropriate remedial actions tailored to bonds involving the Federal direct payment subsidy option under section 6431 in future public guidance.

In addition, except as otherwise provided, §1.1397E-1(h)(2), (h)(3), (h)(4), (i), and (j) of the final regulations regarding the five-year spending period, the arbitrage investment restrictions, and the information reporting requirement added by the 2006 Act apply to bonds issued under section 1397E pursuant to allocations of the national qualified zone academy bond volume cap authority arising in calendar years after 2005 and sold on or after September 14, 2007.

In addition, issuers and taxpayers also may apply the final regulations in whole, but not in part, to bonds issued under section 1397E that are sold before September 14, 2007.

Certain other special effective dates apply to particular provisions under §1.1397E-1(m).

Special Analyses

It has been determined that this Treasury decision is not a significant regulatory action as defined in Executive Order 12866. Therefore, a regulatory assessment is not required. It has also been determined that section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to these regulations. It is hereby certified that the collection of information contained in this regulation will not have a significant economic impact on a substantial number of small entities. Accordingly, a regulatory flexibility analysis is not required. The collection of information in this proposed regulation is in §1.1397E-1(h)(8). This collection of information is required by the IRS to verify compliance with section 1397E. This information will be used to identify issuers of qualified zone academy bonds that have established a defeasance escrow as a remedial action taken because of failure to satisfy certain requirements of section 1397E. The collection of information is

required to obtain or retain a benefit. The likely respondents are states or local governments that issue qualified zone academy bonds. The estimated number of respondents is 6, and the estimated average annual burden hours per respondent is 30 minutes. In addition, the establishment of a defeasance escrow need only be reported once. Accordingly, the number of, and the burden on, affected small entities is not significant. Pursuant to section 7805(f) of the Code, the notice of proposed rulemaking preceding this regulation has been submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on its impact on small businesses.

Drafting Information

The principal author of these regulations is Zoran Stojanovic, Office of Associate Chief Counsel, IRS (Financial Institutions and Products). However, other personnel from the IRS and the Treasury Department participated in their development.

* * * * *

Adoption of Amendments to the Regulations

Accordingly, 26 CFR parts 1 and 602 are amended as follows:

PART 1—INCOME TAXES

Paragraph 1. The authority citation for part 1 is amended by removing the entry for “1.1397E-1T” and revising the entry for “§1.1397E-1” to read as follows

Authority 26 U.S.C. 7805 * * *

Section 1.1397E-1 also issued under 26 U.S.C. 1397E. * * *

Par. 2. Section 1.1397E-1 is amended by revising paragraphs (a), (d), (h), (i), (j) and (m) to read as follows:

§1.1397E-1 Qualified zone academy bonds.

(a) *In general*—(1) *Overview.* In general, a qualified zone academy bond (QZAB or QZABs) is a taxable bond issued by a state or local government the proceeds of which are used to improve certain eligible public schools. An eligible taxpayer that holds a QZAB generally is allowed annual Federal income tax

credits in lieu of periodic interest payments. These credits compensate the eligible taxpayer for lending money to the issuer and function as payments of interest on the bond. Accordingly, this section generally treats the allowance of a credit as if it were a payment of interest on the bond. This section also provides other rules for QZABs, including rules governing the credit rate, the private business contribution requirement, the maximum term, use and expenditure of proceeds, remedial actions, eligible issuers, arbitrage investment restrictions, and information reporting.

(2) *Certain definitions*—(i) *In general.* For purposes of this section, except as otherwise provided in this section, the following definitions apply: the definitions set forth in this section; the definitions used for general tax-exempt bond purposes in §1.150-1; and the definitions used for purposes of the arbitrage investment restrictions on tax-exempt bonds in §1.148-1(b).

(ii) *Applicable definition of proceeds*—(A) *Use and expenditure provisions.* Except as provided in paragraphs (a)(2)(ii)(B) and (a)(2)(ii)(C) of this section, for purposes of all applicable requirements regarding use and expenditure of proceeds of QZABs under section 1397E and this section, “proceeds” means “sale proceeds,” as defined in §1.148-1(b), plus “investment proceeds,” as defined in §1.148-1(b).

(B) *Private business contribution requirement.* For purposes of the private business contribution requirement of section 1397E(d)(2), “proceeds” means “sale proceeds,” as defined in §1.148-1(b).

(C) *Arbitrage investment restrictions.* For purposes of the scope of application of the arbitrage investment restrictions under section 1397E(g) and paragraph (i) of this section, “proceeds” generally means gross proceeds, as defined in §1.148-1(b). In addition, in applying the arbitrage investment restrictions under paragraph (i) of this section and under section 148, the various applicable definitions of the various types of proceeds of tax-exempt bonds under §1.148-1(b) shall apply.

* * * * *

(d) *Maximum term.* The maximum term for a QZAB is determined under section 1397E(d)(3) by using a discount rate equal to 110 percent of the long-term

adjusted applicable Federal rate (AFR), compounded semi-annually, for the month in which the bond is sold. The Internal Revenue Service publishes this figure each month in a revenue ruling that is published in the Internal Revenue Bulletin. See §601.601(d)(2)(ii)(b) of this chapter. A bond is sold on the sale date, as defined in §1.150-1(c)(6), which is the first day on which there is a binding contract in writing for the sale or exchange of the bond.

* * * * *

(h) *Use of proceeds*—(1) *In general.* Section 1397E(d)(1) provides that a bond issued as part of an issue is a QZAB only if, among other requirements, at least 95 percent of the proceeds of the issue are to be used for a qualified purpose with respect to a qualified zone academy established by an eligible local education agency (as defined in section 1397E(d)(4)(B)), and the issue meets the requirements of section 1397E(f) and (g). Section 1397E(d)(5) defines *qualified purpose*, with respect to any qualified zone academy, as rehabilitating or repairing the public school facility in which such academy is established, providing equipment for use at such academy, developing course materials for education to be provided at such academy, and training teachers and other school personnel in such academy. Section 1397E(d)(4)(A) defines *qualified zone academy* as any public school (or academic program within a public school) that is established by and operated under the supervision of an eligible local education agency to provide education or training below the postsecondary level and that meets the requirements of section 1397E(d)(4)(A)(i), (ii), (iii) and (iv).

(2) *Use of proceeds requirements.* An issue meets the requirements of sections 1397E(d)(1)(A) and (f) only if—

(i) The issuer reasonably expects, as of the issue date of the issue, that—

(A) At least 95 percent of the proceeds from the sale of the issue are to be spent for qualified purposes with respect to qualified zone academies within the 5-year period beginning on the issue date of the QZAB;

(B) A binding commitment with a third party to spend at least 10 percent of the proceeds from the sale of the issue will be incurred within the 6-month period beginning on the issue date of the QZAB;

(C) At least 95 percent of the proceeds from the sale of the issue will be spent for qualified purposes with respect to a qualified zone academy with due diligence (with due diligence measured by the reasonableness standard under §1.148-1(b)); and

(D) At least 95 percent of the proceeds of the issue will be used for qualified purposes with respect to a qualified zone academy for the entire term of the issue (without regard to any redemption provision); and

(ii) Except as otherwise provided in paragraph (h)(8) of this section, at least 95 percent of the proceeds of the issue are actually used for qualified purposes with respect to a qualified academy for the entire term of the issue (without regard to any redemption provision).

(3) *Extension of 5-year period.* The Commissioner may extend the period described in paragraph (h)(2)(i)(A) of this section if the issuer, prior to the end of such period, submits a private ruling request, and establishes to the satisfaction of the Commissioner that—

(i) The failure to satisfy the 5-year spending requirement is due to reasonable cause; and

(ii) The expenditure of at least 95 percent of the proceeds from the sale of the issue for a qualified purpose with respect to a qualified zone academy will continue to proceed with due diligence.

(4) *Unspent proceeds.* For purposes of paragraphs (h)(2)(i)(D) and (h)(2)(ii) of this section, during the period described in paragraph (h)(2)(i)(A) of this section, including any extension under paragraph (h)(3) of this section, unspent proceeds are treated as used for a qualified purpose with respect to a qualified zone academy if the issuer reasonably expects to proceed with due diligence to spend those proceeds for a qualified purpose with respect to a qualified zone academy during that period.

(5) *Proceeds spent for rehabilitation, repair or equipment*—(i) *In general.* Under section 1397E(d)(5)(A) the term *qualified purpose* with respect to any qualified zone academy includes rehabilitating or repairing the public school facility in which such academy is established. For this purpose, in determining whether proceeds are spent for rehabilitation, rules similar to those under section 47(c) (other than sections 47(c)(1)(B) and

47(c)(2)(B)(iv)) shall apply. Under section 1397E(d)(5)(B) the term *qualified purpose* also includes providing equipment for use at such academy. If proceeds of an issue are spent for a purpose described in section 1397E(d)(5)(A) or (B) with respect to a qualified zone academy, then those proceeds are treated as used for a qualified purpose with respect to the academy during any period after such expenditure that—

(A) The property financed with those proceeds is used for the purposes of the academy; and

(B) The academy maintains its status as a qualified zone academy under section 1397E(d)(4).

(ii) *Retirement from service.* The retirement from service of financed property due to normal wear or obsolescence does not cause the property to fail to be used for a qualified purpose with respect to a qualified zone academy.

(6) *Proceeds spent to develop course materials or train teachers.* Section 1397E(d)(5)(C) and (D) provides that the term *qualified purpose* with respect to any qualified zone academy includes developing course materials for education to be provided at such academy, and training teachers and other school personnel in such academy. If proceeds of an issue are spent for a purpose described in section 1397E(d)(5)(C) or (D) with respect to a qualified zone academy, then those proceeds are treated as used for a qualified purpose with respect to the academy during any period after such expenditure.

(7) *Special rule for determining status as qualified zone academy.* Section 1397E(d)(4)(A)(iv) provides that a public school (or academic program within a public school) is a qualified zone academy only if, among other requirements, the public school is located in an empowerment zone or enterprise community (as defined in section 1393), or there is a reasonable expectation (as of the issue date of the issue) that at least 35 percent of the students attending the school or participating in the program (as the case may be) will be eligible for free or reduced-cost lunches under the school lunch program established under the Richard B. Russell National School Lunch Act. For purposes of determining whether an issue complies with section 1397E(d)(4)(A)(iv)—

(i) A public school is treated as located in an empowerment zone or enterprise community for the entire term of the issue if the public school is located in an empowerment zone or enterprise community on the issue date of the issue; and

(ii) The determination of whether there is a reasonable expectation (as of the issue date of the issue) that at least 35 percent of the students attending the school or participating in the program (as the case may be) will be eligible for free or reduced-cost lunches under the school lunch program established under the Richard B. Russell National School Lunch Act is based on expectations regarding the one-year period following the issue date.

(8) *Remedial actions*—(i) *General rule*. If less than 95 percent of the proceeds of an issue are properly used (as determined under paragraph (h)(8)(ii)(D) of this section), the issue will be treated as meeting the requirements of section 1397E(d)(1)(A) if the issue met the requirements of paragraph (h)(2)(i) of this section and a remedial action is taken under paragraph (h)(8)(ii) or (iii) of this section.

(ii) *Redemption or defeasance*—(A) *In general*. A remedial action is taken under this paragraph (h)(8)(ii) if the requirements of paragraphs (h)(8)(ii)(B) and (C) of this section are met.

(B) *Retirement of nonqualified bonds*—(1) *In general*. The requirements of this paragraph (h)(8)(ii)(B) are met if—

(i) All of the nonqualified bonds of the issue (as determined under §1.142–2(e)) are redeemed within 90 days after the date on which the failure to properly use proceeds occurs; or

(ii) To the extent proceeds of the issue that have been actually spent for a qualified purpose with respect to a qualified zone academy, if any nonqualified bonds of the issue are not redeemed within 90 days after the date on which the failure to properly use such proceeds occurs (the unredeemed nonqualified bonds), a defeasance escrow is established for the unredeemed nonqualified bonds within 90 days after the date on which the failure to properly use proceeds occurs.

(2) *Special rule for dispositions for cash*. If the failure to properly use proceeds occurs because of a disposition of financed property described in section 1397E(d)(5)(A) or (B) and the consid-

eration for the disposition is exclusively cash, the requirements of this paragraph (h)(8)(ii)(B) are met if all of the disposition proceeds (as defined in paragraph (h)(8)(iv) of this section) are used within 90 days after the date of the disposition to redeem, or establish a defeasance escrow for, the nonqualified bonds (as determined under §1.142–2(e)).

(3) *Definition of defeasance escrow*. For purposes of this section, a defeasance escrow is an irrevocable escrow established to retire nonqualified bonds on the earliest call date after the date on which the failure to properly use proceeds occurs in an amount that is sufficient to retire nonqualified bonds on that call date. At least 90 percent of the weighted average amount in a defeasance escrow must be invested in investments (as defined in §1.148–1(b)), except that no amount in a defeasance escrow may be invested in any investment the obligor (or any person that is a related party with respect to the obligor within the meaning of §1.150–1(b)) of which is a user of proceeds of the bonds. All purchases or sales of an investment in a defeasance escrow must be made at the fair market value of the investment within the meaning of §1.148–5(d)(6).

(C) *Additional rules*—(1) *Limitation on source of funding*. Proceeds of an issue of QZABs (other than unspent proceeds of the issue for which the failure to properly use proceeds occurs) must not be used to redeem or defease nonqualified bonds under paragraph (h)(8)(ii)(B) of this section.

(2) *Rebate requirement*. The issuer must pay to the United States, at the same time and in the same manner as rebate amounts are required to be paid under §1.148–3 (or at such other time or in such other manner as the Commissioner may prescribe), any investment earnings on amounts in a defeasance escrow established under paragraph (h)(8)(ii)(B) of this section that are in excess of the yield on the issue of QZABs with respect to which the defeasance escrow was established. For this purpose, the first computation period begins on the date on which the defeasance escrow is established.

(3) *Notice of defeasance*. The issuer must provide written notice to the Commissioner, at the place designated in §1.150–5(a), of the establishment of the defeasance escrow within 90 days of the date the defeasance escrow is established.

(D) *When a failure to properly use proceeds occurs*—(1) *Unspent proceeds*. For unspent proceeds, a failure to properly use proceeds occurs on the earliest of—

(i) The first date on which the public school (or academic program within the public school) fails to constitute a qualified zone academy;

(ii) The first date on which the issuer fails to have a reasonable expectation to proceed with due diligence to spend at least 95 percent of the proceeds of the issue for a qualified purpose with respect to a qualified zone academy; or

(iii) The last day of the period described in paragraph (h)(2)(i)(A) of this section, including any extension, if less than 95 percent of the proceeds of the issue are actually spent for a qualified purpose with respect to a qualified zone academy.

(2) *Proceeds spent for rehabilitation, repair or equipment*. For proceeds that have been spent for a purpose described in section 1397E(d)(5)(A) or (B) with respect to a qualified zone academy, a failure to properly use proceeds occurs on the earlier of—

(i) The first date on which the public school (or academic program within the public school) fails to constitute a qualified zone academy; and

(ii) The first date on which an action is taken that causes the issuer to fail actually to use at least 95 percent of the proceeds of the issue for a qualified purpose with respect to a qualified zone academy.

(3) *Proceeds spent for course materials or training*. If proceeds have been spent for a purpose described in section 1397E(d)(5)(C) or (D) with respect to a qualified zone academy, no event subsequent to such expenditure shall constitute a failure to properly use such proceeds.

(iii) *Alternative use of disposition proceeds*. A remedial action is taken under this paragraph (h)(8)(iii) if all of the requirements of paragraphs (h)(8)(iii)(A) through (D) of this section are met—

(A) The failure to properly use proceeds (as determined under paragraph (h)(8)(ii)(D) of this section) is a disposition of financed property described in section 1397E(d)(5)(A) or (B) and the consideration for the disposition is exclusively cash;

(B) The issuer reasonably expects as of the date of the disposition that—

(I) All of the disposition proceeds will be spent within the two-year period beginning with the date of the disposition for a qualified purpose with respect to a qualified zone academy; or

(2) To the extent not expected to be so spent, the disposition proceeds will be used within 90 days after the date of the disposition to redeem or defease bonds in a manner that meets the requirements of paragraph (h)(8)(ii) of this section;

(C) The disposition proceeds are treated as proceeds for purposes of section 1397E; and

(D) If all of the disposition proceeds are not actually used in the manner described in paragraph (h)(8)(iii)(B) of this section, the remainder of such amounts are used within 90 days after the end of the period described in paragraph (h)(8)(iii)(B)(I) of this section for a remedial action that meets the requirements of paragraph (h)(8)(ii) of this section.

(iv) *Definition of disposition proceeds and allocation among multiple funding sources.* For purposes of this paragraph (h)(8), *disposition proceeds* means disposition proceeds, as defined in §1.141–12(c)(1), plus amounts derived from investing disposition proceeds. If property has been financed with an issue of QZABs and one or more other funding sources, any disposition proceeds from that property are allocated to the issue under the principles of §1.141–12(c)(3).

(9) *Payment of principal, interest or redemption price—(i) In general.* Except as provided in paragraphs (h)(9)(ii) and (h)(9)(iii) of this section, the use of proceeds of a bond to pay principal, interest, or redemption price of the bond or another bond is not a qualified purpose within the meaning of section 1397E(d)(5).

(ii) *Exception for certain eligible reimbursements of interim refinancings.* The use of proceeds of a bond (the refinancing bond) to pay principal, interest, or redemption price of another bond (the prior bond) is a qualified purpose within the meaning of section 1397E(d)(5) to the extent that—

(A) The prior bond was not a QZAB (and, in the case of a series of refinancings, no earlier bond in the series was a QZAB);

(B) The proceeds of the prior bond (or the original bond in the case of a series of refinancings, as applicable) were spent for a qualified purpose under section 1397E(d)(5) with respect to a qualified

zone academy (the original expenditure); and

(C) The issuer makes a valid reimbursement allocation to allocate the proceeds of the refinancing bond to the payment of the original expenditure (the reimbursement allocation), which allocation satisfies the requirements for reimbursements under paragraph (h)(10) of this section. For purposes of applying the rules for reimbursement, a refinancing bond which otherwise meets the requirements of this paragraph (h)(9)(ii) is eligible for reimbursement and is not treated as a disqualified refunding under §1.150–2(g).

(iii) *Reissuance of a QZAB.* For purposes of determining whether the establishing of a defeasance escrow under paragraph (h)(8)(ii)(B)(I)(ii) of this section results in an exchange under §1.1001–1(a), the QZAB is treated as a tax-exempt bond under §1.1001–3(e)(5)(ii)(B)(I).

(10) *Reimbursement.* An expenditure for a qualified purpose may be reimbursed with proceeds of a QZAB. For this purpose, rules similar to those on reimbursement of expenditures in §1.142–4(b) and §1.150–2 shall apply. In applying these reimbursement rules, expenditures eligible for reimbursement under §1.150–2(d)(3) shall be deemed to mean any expenditure for a qualified purpose under section 1397E(d)(5).

(i) *Arbitrage investment restrictions—(1) In general.* Under section 1397E(g) and this paragraph (i), and except as otherwise provided in this paragraph (i), the arbitrage investment restrictions and rebate requirements under section 148 and §§1.148–1 through 1.148–11, inclusive, and the exceptions to those restrictions, apply broadly to gross proceeds of QZABs issued under section 1397E to the same extent and in the same manner as they apply to gross proceeds of tax-exempt state or local governmental bonds. For this purpose, references in those sections to tax-exempt bonds generally shall be deemed to refer to QZABs and, to the extent that any particular arbitrage restriction depends on whether bonds are private activity bonds under section 141, the determination of whether QZABs are private activity bonds shall be based on the general definition of private activity bonds under section 141. In applying section 148 and the regulations under that section to QZABs, the modifications set

forth in paragraphs (i)(2) through (i)(6) of this section shall apply.

(2) *5-year temporary period exception to arbitrage yield restriction.* If an issue of QZABs meets the requirements of section 1397E(f)(1) and paragraph (h)(2)(i) of this section, then the proceeds of the issue of QZABs are treated as qualifying for a 5-year temporary period exception to arbitrage yield restriction under §1.148–2(e)(2) beginning on the issue date of the issue.

(3) *Disregard QZAB credit in QZAB yield for arbitrage purposes.* In determining the yield on an issue of QZABs for arbitrage purposes under §1.148–4, the QZAB credit allowed under section 1397E(a) is disregarded.

(4) *Non-AMT tax-exempt bond investment exception inapplicable.* The exception to arbitrage yield restriction for investments of gross proceeds of tax-exempt bonds in specified tax-exempt bond investments not subject to section 148(b)(3)(B) (relating to an exception to the definition of “investment property” for specified tax-exempt bonds) and §1.148–2(d)(2)(v) (relating to a corresponding exception to arbitrage yield limitations) is inapplicable.

(5) *Application of small issuer exception to the arbitrage rebate requirement.* Except as otherwise provided in paragraph (i)(6) of this section, for purposes of the small issuer exception to the arbitrage rebate requirement under section 148(f)(4)(D) and §1.148–8, QZABs that are actually issued or reasonably expected to be issued by the QZAB issuer (and applicable entities aggregated under section 148(f)(4)(D)) within a calendar year are taken into account in measuring the applicable size limitation.

(6) *Certain defeasance escrow earnings.* With respect to a defeasance escrow established in a remedial action for an issue of QZABs that meets the special rebate requirement under paragraph (h)(8)(ii)(C)(2) of this section, the QZAB issuer is treated as ineligible for the small issuer exception to arbitrage rebate under section 148(f)(4)(D) and paragraph (i)(5) of this section and compliance with that special rebate requirement is treated as satisfying applicable arbitrage investment restrictions under section 148 for that defeasance escrow.

(j) *Information reporting requirement.* Under section 1397E(h) and this paragraph

(j), issuers of QZABs are required to submit information reporting returns to the IRS similar to the information reporting returns required to be submitted to the IRS under section 149(e) for tax-exempt state or local governmental bonds at the same time and in the same manner as those reports are required to be submitted to the IRS on such forms as shall be prescribed by the Commissioner for such purpose.

* * * * *

(m) *Effective/applicability dates*—(1) *In general.* Except as otherwise provided in this paragraph (m), this section applies to bonds issued under section 1397E that are sold on or after September 14, 2007.

(2) *Special effective dates*—(i) *Effective dates for paragraphs (h)(2), (h)(3), (h)(4), (i), and (j) of this section in general.* Paragraphs (h)(2), (h)(3), (h)(4), (i), and (j) of this section apply to bonds issued under section 1397E pursuant to allocations of the national qualified zone academy bond volume cap authority for calendar years after 2005 and sold on or after September 14, 2007.

(ii) *Permissive retroactive application*—(A) *In general.* Except as otherwise provided in this paragraph (m), issuers and taxpayers may apply this section in whole, but not in part, to bonds issued

under section 1397E that are sold before September 14, 2007.

(B) *Special rule for certain provisions.* For purposes of the permissive retroactive application rule in paragraph (m)(2)(ii)(A) of this section, paragraphs (h)(2), (h)(3), (h)(4), (i), and (j) of this section need not be applied to any bonds issued under section 1397E to which those provisions do not otherwise apply under the general effective date provisions for those provisions in paragraph (m)(2)(i) of this section.

(C) *Definition of proceeds.* Issuers and taxpayers may apply paragraph (h) of this section, without regard to the definition of proceeds in paragraph (a)(2)(ii) of this section, to bonds issued under section 1397E that are sold before September 14, 2007.

(D) *Bonds issued before July 1, 1999.* Paragraphs (b) and (h)(10) of this section may not be applied to bonds issued under section 1397E that are issued before July 1, 1999.

(3) *Scope of reliance for bonds issued under sections 54A and 54E.* Except to the extent inconsistent with the successor statutory provisions for QZABs in sections 54A and 54E or applicable public administrative or regulatory guidance under those provisions and except as otherwise provided in this paragraph (m)(3), issuers and taxpayers may apply these regulations

to QZABs issued under sections 54A and 54E that are sold after October 3, 2008. In the case of QZABs that are issued under sections 54A and 54E for which the issuer makes an irrevocable election under section 6431(f) to receive payments with respect to credits under section 6431, issuers and taxpayers may not apply the remedial action provisions under paragraph (h)(8) of this section.

§1.1397E–1T [Removed]

Par. 3. Section 1.1397E–1T is removed.

PART 602—OMB CONTROL NUMBERS UNDER THE PAPERWORK REDUCTION ACT

Par. 4. The authority citation for part 602 continues to read as follows:

Authority: 26 U.S.C. 7805.

Par. 5. In §602.101, paragraph (b) is amended by removing the entry for “1.1397E–1T” and adding the following entry in numerical order to the table to read as follows:

§602.101 OMB Control numbers.

* * * * *

(b) * * *

CFR part or section where identified and described	Current OMB control No.
* * * * *	
1.1397E–1	1545–1908
* * * * *	

Steven T. Miller,
Deputy Commissioner for
Services and Enforcement.

Michael Mundaca,
Assistant Secretary
of the Treasury (Tax Policy).

(Filed by the Office of the Federal Register on July 29, 2010, 8:45 a.m., and published in the issue of the Federal Register for July 30, 2010, 75 F.R. 44901)

Approved July 16, 2010.

Section 6050W.—Returns Relating to Payments Made in Settlement of Payment Card and Third Party Network Transactions

26 CFR 1.6050W-1: Information reporting for payments made in settlement of payment card and third party network transactions.

T.D. 9496

DEPARTMENT OF THE TREASURY

Internal Revenue Service
26 CFR Parts 1, 31, and 301

Information Reporting for Payments Made in Settlement of Payment Card and Third Party Network Transactions

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Final regulations.

SUMMARY: This document contains final regulations relating to information reporting requirements, information reporting penalties, and backup withholding requirements for payment card and third party network transactions. The final regulations implement section 6050W and related statutory changes enacted by the Housing Assistance Tax Act of 2008 that require payment settlement organizations to report payments in settlement of payment card and third party network transactions for each calendar year. The final regulations in this document will affect persons that make payment in settlement of payment card and third party network transactions and the payees of these transactions. The final regulations provide guidance to assist persons required to report payment card and third party network transactions and to the payees of those transactions.

DATES: *Effective Date:* These regulations are effective on August 16, 2010.

Applicability	Date:	For
dates of applicability,	see	
§§ 1.6041-1(j),	1.6041A-1(d)(4)(iii),	
1.6050W-1(j), 1.6050W-2(b),		
31.3406-(b)(3)-5(e).		

FOR FURTHER INFORMATION CONTACT: Concerning these final regulations, Barbara Pettoni, (202) 622-4910 (not a toll-free number).

SUPPLEMENTARY INFORMATION:

Background

This document contains final regulations implementing amendments to the Income Tax Regulations (26 CFR part 1) relating to information reporting under sections 6041, 6041A, 6050W, and 6051 of the Internal Revenue Code (Code). This document also contains final regulations implementing amendments to the Regulations on Employment Tax and Collection of Income Tax at the Source (26 CFR part 31) relating to backup withholding under section 3406, and to the Regulations on Procedure and Administration (26 CFR part 301) relating to information reporting penalties under sections 6721 and 6722. These sections were amended or added by section 3091(a) of the Housing Assistance Tax Act of 2008 (Div. C of the Housing and Economic Recovery Act of 2008), Public Law No. 110-289, 122 Stat. 2654 (the Act) enacted on July 30, 2008. These regulations are issued under the authority contained in sections 6041, 6041A, 6050W, 6051, 3406, 6721, 6722 and 7805.

On February 6, 2009, the IRS announced that persons who will be required to report under section 6050W may match Taxpayer Identification Numbers (TINs) under the procedures established by Rev. Proc. 2003-9. See Announcement 2009-6, "Taxpayer Identification Number ("TIN") Matching Program is Available to Persons Required to Make Returns Under New Section 6050W of the Internal Revenue Code" (Announcement 2009-6, 2009-9 I.R.B. 643 (March 2, 2009)). See §601.601(d)(2)(ii)(b).

Notice 2009-19 invited public comments regarding guidance under section 6050W. See Notice 2009-19, "Information Reporting of Payments Made in Settlement of Payment Card and Third Party Network Transactions" (Notice 2009-19, 2009-10 I.R.B. 660 (March 9, 2009)).

On November 24, 2009, the Treasury Department and the IRS published in the **Federal Register** (74 FR 61294) proposed regulations (REG-139255-08, 2009-49 I.R.B. 747) reflecting the new require-

ments of the Act. The comments received in response to Notice 2009-19 were taken into account in developing the proposed regulations. Written comments were also received in response to the proposed regulations, and a public hearing was held on March 15, 2010.

Summary of Comments and Explanation of Revisions

Many written comments were received and are available for public inspection upon request. The comments are summarized in this preamble. After considering the public comments, the Treasury Department and the IRS are adopting the proposed regulations as revised by this Treasury decision.

These final regulations provide guidance to implement section 6050W, which requires information reporting for payments made in settlement of payment card and third party network transactions. These final regulations also amend the existing regulations under sections 6041 and 6041A to provide relief from duplicate reporting for certain transactions. In addition, these final regulations amend existing regulations under sections 6721 and 6722 to expand the penalty provisions of these sections to apply to failures to file correct information returns required by section 6050W and to furnish correct payee statements required by section 6050W. These final regulations also amend existing regulations under section 3406 to provide that amounts reportable under section 6050W are subject to backup withholding.

Payment Settlement Entity

Section 6050W(b)(1) provides that the term *payment settlement entity* means, in the case of a payment card transaction, a merchant acquiring entity; and, in the case of a third party network transaction, a third party settlement organization. Section 6050W(b)(2) defines *merchant acquiring entity* as the bank or other organization with the contractual obligation to make payment to participating payees in settlement of payment card transactions. Section 6050W(b)(3) defines *third party settlement organization* as the central organization that has the contractual obligation to make payment to participating payees of third party network transactions.

The proposed regulations incorporated these statutory definitions, which are retained in the final regulations.

Commenters asked how the reporting obligation applies when two or more persons qualify as payment settlement entities for a reportable payment transaction. Commenters stated that, under certain business models, multiple banks or other organizations have the contractual obligation to make payment to participating payees to settle payment card transactions. The final regulations provide that, if two or more persons qualify as payment settlement entities for a reportable payment transaction, then only the payment settlement entity that in fact makes payment in settlement of the reportable payment transaction is obligated to report the payment. The final regulations clarify that the entity that makes a payment in settlement of a reportable payment transaction is the entity that actually submits the instruction to transfer funds to the account of the participating payee to settle the reportable payment transaction. See also the discussion under “Electronic Payment Facilitator” later in this preamble.

A commenter requested that, when multiple parties qualify as payment settlement entities, the parties be permitted to designate a reporting party. Under the final regulations, only the payment settlement entity that in fact makes payment is obligated to report the payment. Thus, no multiple party reporting obligations should arise. Nonetheless, the final regulations permit the party with the obligation to report to designate a different person to satisfy the reporting obligation under section 6050W. If, however, the designated person fails to satisfy the reporting obligation, then the party with the obligation to report is liable for any applicable penalties under sections 6721 and 6722.

Gross Amount

Section 6050W(a) provides that each payment settlement entity must report the gross amount of reportable payment transactions for each participating payee. The proposed regulations defined *gross amount* as the total dollar amount of aggregate reportable payment transactions for each participating payee without regard to any adjustments for credits, cash equiv-

alents, discount amounts, fees, refunded amounts, or any other amounts.

Several commenters suggested defining “gross amount” as net sales, taking into account credit transactions, chargebacks and other adjustments, on the ground that gross amount is not a true indicator of revenue. Commenters also suggested defining “gross amount” as the amount actually paid to a merchant. Other commenters favored the rule in the proposed regulations that would require reporting the gross amount of transactions without reductions. The final regulations retain the proposed rule. The plain language of the statute requires reporting the gross amount of transactions rather than the net amount of transactions or payments. The information reported on the return required under these regulations is not intended to be an exact match of the net, taxable, or even the gross income of a payee.

Commenters asked whether the dollar amount of each transaction is determined on the date of the transaction, the settlement date, the date that payment is made, the posting date or some other date. Because the statute requires reporting of the gross amount of reportable payment “transactions,” the final regulations provide that the dollar amount of each reportable payment transaction is determined on the date of the transaction.

Several commenters expressed concern that defining “gross amount” as a number that reflects all positive sales transactions without adjustment for any items may raise issues related to backup withholding. These comments are discussed in detail later in this preamble.

Payment Card Transactions

Section 6050W(c)(2) defines a *payment card transaction* as any transaction in which a payment card is accepted as payment. Section 6050W(d)(2) defines a *payment card* as a card issued pursuant to an agreement or arrangement that provides for: (1) one or more issuers of such cards; (2) a network of persons unrelated to each other, and to the issuer, who agree to accept the cards as payment; and (3) standards and mechanisms for settling the transactions between the merchant acquiring entities and the persons who agree to accept the cards as payment. Section 6050W(d)(2) further provides that the

acceptance as payment of any account number or other indicia associated with a payment card is treated as the acceptance of the payment card. The proposed regulations incorporated these statutory rules. The proposed regulations further provided that a payment card includes, but is not limited to, all credit cards, debit cards, and stored-value cards (including gift cards). All of these provisions are retained in the final regulations.

Several commenters requested an exemption for all private label cards and quasi-private label cards. According to one commenter, a private label card is a card issued by a retailer or financial institution that can only be used at one retailer, and a quasi-private label card is a card issued by a financial institution that can be used within a limited network of merchants or service providers that are unrelated but operate within a particular industry or share other similar characteristics. Another commenter requested that the regulations clarify whether a card that is accepted as payment by a group of merchants operating within a shopping mall (a “mall card”) is a payment card.

The final regulations do not provide an exemption for private label cards, quasi-private label cards and mall cards. Private label cards that can only be used at one merchant or within a group of related merchants do not meet the statutory definition of payment card because they are not accepted as payment by a network of unrelated persons. Quasi-private label cards that are accepted as payment by a network of unrelated merchants or service providers are payment cards if the other requirements of the statutory definition are met. Similarly, a mall card is a payment card if it is accepted as payment by a network of unrelated merchants and the other requirements of the statutory definition are met. However, if any of the merchants in the network are related to the issuer, as might be the case in certain campus card or mall card transactions, the final regulations clarify that no reporting is required for any transaction in which the card is accepted as payment by the related merchant or other payee. The final regulations provide additional examples to illustrate the treatment of private label, quasi-private label and mall cards.

One commenter requested that the regulations clarify whether electronic benefit

transactions are reportable transactions under the regulations. According to the commenter, electronic benefit transactions are transactions made on cards or other media issued by a governmental unit for benefit payments, such as food stamps, welfare or unemployment. A card issued by a governmental unit for benefits is a payment card if, pursuant to an agreement, it is accepted as payment by a network of unrelated merchants and the other requirements of the statutory definition are met. Electronic benefit transactions for the purchase of goods or services, made on a card that meets the statutory definition of “payment card,” are reportable under section 6050W. In contrast, the use of a benefits card to obtain cash would not be a reportable transaction, as discussed in the next paragraph.

Commenters asked whether the use of a payment card solely to obtain a loan or cash advance by the cardholder is reportable under the regulations. The final regulations provide an example to clarify that the use of a payment card to obtain a loan or cash advance does not fall within the statutory definition of “payment card transaction” because the card is not being accepted by a merchant as payment. Rather, the cardholder is merely using the payment card to obtain a loan from the issuer. Similarly, the withdrawal of cash from an automated teller machine is not a payment card transaction because the card is not being accepted by a merchant as payment. Rather, the card is merely being used to obtain funds from the cardholder’s own account.

Commenters also asked whether the use of a paper check associated with a payment card account (a “convenience check”) is reportable under the regulations. Section 6050W(d)(2) provides that the acceptance as payment of any account number or other indicia associated with a payment card is treated as the acceptance of the payment card. Convenience checks are processed through the banking system in the same manner as a traditional check and then processed against a cardholder’s account as a cash advance. Because convenience checks are accepted and processed as checks, not as payment cards, the final regulations provide an example to clarify that the use of a convenience check is not a “payment card transaction.”

Third Party Network Transactions

Section 6050W(b)(1)(B) provides that, in the case of a third party network transaction, the payment settlement entity is the third party settlement organization. Section 6050W(b)(3) defines *third party settlement organization* as the central organization that has the contractual obligation to make payment to participating payees of third party network transactions. Section 6050W(c)(3) defines *third party network transaction* as any transaction that is settled through a third party payment network. Section 6050W(d)(3) defines *third party payment network* as any agreement or arrangement that: (A) involves the establishment of accounts with a central organization by a substantial number of persons who (i) are unrelated to such organization, (ii) provide goods or services, and (iii) have agreed to settle transactions for the provision of such goods or services pursuant to such agreement or arrangement; (B) provides for standards and mechanisms for settling such transactions; and (C) guarantees persons providing goods or services pursuant to an agreement or arrangement that those persons will be paid for providing those goods or services.

The proposed regulations incorporated these statutory definitions. The proposed regulations also provided that, consistent with the Joint Committee on Taxation (JCT) technical explanation, a central organization is a third party settlement organization that is required to report to the extent it provides a third party payment network that enables purchasers to transfer funds to providers of goods and services. These provisions are retained in the final regulations.

One commenter suggested that the regulations also incorporate the rule in section 6050W(d)(3) that a third party payment network does not include any agreement or arrangement that provides for the issuance of payment cards. The final regulations adopt this suggestion.

Healthcare Networks and Self-Insurance Arrangements

The proposed regulations included an example to demonstrate that health insurance networks are outside the scope of section 6050W because a healthcare net-

work does not enable the transfer of funds from buyers to sellers. Instead, health carriers collect premiums from covered persons pursuant to a plan agreement between the health carrier and the covered person for the cost of participation in the healthcare network. Separately, health carriers pay healthcare providers to compensate providers for services rendered to covered persons pursuant to provider agreements. This example is retained in the final regulations.

A commenter requested that the final regulations clarify that a self-insurance arrangement is also outside the scope of section 6050W. According to the commenter, a typical self-insurance arrangement involves a health insurance entity, healthcare providers, and the company that is self-insuring. The company submits bills for services rendered by a healthcare provider to the health insurance entity. The health insurance entity pays the healthcare provider the contracted rate and then debits the self-insuring company’s bank account for the payments made to the healthcare providers.

This suggestion was not adopted because this arrangement could create a third party payment network of which the health insurance entity is the third party settlement organization to the extent that the health insurance entity effectively enables buyers (the self-insuring companies) to transfer funds to sellers of healthcare goods or services. If so, payments under a self-insurance arrangement are reportable provided the arrangement meets both the statutory definition of a third party payment network and the *de minimis* threshold (that is, for a given payee, the aggregate payments for the year exceed \$20,000 and the aggregate number of transactions exceeds 200).

Electronic Checks, Bill Paying Services and Other Electronic Payment Acceptance Products

Several commenters requested that the final regulations exclude electronic checks, bill paying services, and other electronic payment acceptance products from the scope of section 6050W. Financial institutions offer a wide array of services to allow individual and business customers to make and receive payments. Whether arrangements involving elec-

tronic checks, bill paying services or other electronic payment acceptance products fall within the statutory definition of “third party payment network” depends on the facts and circumstances. For example, a customer initiated bill payment by means of an electronic check from the customer’s bank account to the merchant is merely an electronic transfer of funds from the buyer to the seller that would generally not meet the definition of a third party payment network.

In contrast, in certain arrangements, a third party entity may facilitate bill payment and presentment. According to one commenter, many financial institutions offer products and services that allow a commercial customer who provides goods or services to (1) send a purchase invoice electronically to customers; and (2) accept payment from these customers by automated clearinghouse (ACH) transfer. In these arrangements, the financial institution typically enters into an agreement with the merchant customer to settle payment transactions to an account the merchant has established at the financial institution. The individual or business that has purchased goods or services from the merchant is not required to establish an account with the financial institution. For payments that are made by ACH transfer, the financial institution will initiate payment through the ACH network. Commenters contend that these arrangements should not qualify as third party payment networks because the arrangements require merchants to establish accounts with a financial institution to accept electronic payment services but do not also require purchasers to establish accounts with the same financial institution. The commenters requested modifying the definition of a third party payment network to require purchasers to establish accounts with the same central organization as the merchant providers in order to participate in the arrangement.

This suggestion was not adopted. The portion of the statutory definition of “third party payment network” relating to accounts requires only that the agreement or arrangement involve the establishment of accounts with a central organization by a substantial number of unrelated persons who provide goods or services and have agreed to settle transactions for the provision of goods or services pursuant to the

agreement or arrangement. Nothing in this definition requires purchasers also to have established accounts with the same central organization. Therefore, a financial institution that enters into an agreement or arrangement with its merchant customers to settle payment transactions to an account the merchant customer has established at the financial institution may be operating a “third party payment network” if the agreement or arrangement with these merchants involves the establishment of accounts with a central organization by a substantial number of unrelated persons who provide goods or services and have agreed to settle transactions for the provision of goods or services pursuant to the agreement or arrangement, and the central organization guarantees payment to those persons for the goods or services.

Automated Clearing House (ACH) Networks

The proposed regulations provided that an ACH network is not a third party payment network. As explained in the preamble to the proposed regulations, an ACH merely processes electronic payments between payors and payees, and does not itself have contractual agreements with payees to use the ACH network. Thus, the ACH does not meet the statutory definition of a “third party settlement organization.”

A commenter asked that the regulations provide that an ACH processor is not a third party settlement organization of a third party payment network. According to the commenter, an ACH processor provides a variety of ACH payment processing services to a large number of merchants, such as converting checks received in payment of bills into ACH transactions. The ACH processor groups payment transactions into an ACH file and transmits the ACH file into the ACH network on behalf of merchants in order to initiate payment to merchants through the ACH network. The ACH processor will make the payment to the merchant after the ACH network verifies that the customers’ accounts have sufficient funds.

This request was not adopted. An ACH processor’s agreement or arrangement with merchants could potentially create an independent third party payment network separate from the ACH network of which the ACH processor is the third party set-

tlement organization. Because the ACH itself is not a third party settlement organization, a party that makes payment on behalf of an ACH cannot be an electronic payment facilitator because it is not acting on behalf of a payment settlement entity. Nonetheless, an entity that initiates ACH entries into an ACH network on behalf of merchants may itself be operating a network that falls within the statutory definition of “third party payment network” if the entity has a separate agreement or arrangement with these merchants that: (A) involves the establishment of accounts with the entity by a substantial number of merchants or other persons who (i) are unrelated to the entity, (ii) provide goods or services, and (iii) have agreed to settle transactions for the provision of such goods or services pursuant to such agreement or arrangement; (B) provides for standards and mechanisms for settling such transactions; and (C) guarantees persons providing goods or services pursuant to such agreement or arrangement that those persons will be paid for providing such goods or services. Whether an entity that initiates ACH entries into an ACH network has such a separate agreement or arrangement with merchants depends on the facts and circumstances. As stated earlier, the statutory definition of “third party payment network” does not require that this entity also have an agreement or arrangement with purchasers.

Electronic Payment Facilitators

Section 6050W(b)(4)(B) requires that, if an *electronic payment facilitator* or other third party “makes payments in settlement of reportable payment transactions on behalf of the payment settlement entity,” the electronic payment facilitator must report in lieu of the payment settlement entity. The proposed regulations incorporated this statutory requirement, which is retained in the final regulations.

Commenters requested that the final regulations clarify what it means to “make payments in settlement of reportable payment transactions on behalf of the payment settlement entity.” According to one commenter, when a merchant acquiring bank employs the services of a third party processor, the settlement obligation remains with the merchant acquiring bank. Another commenter stated that certain

payment settlement entities, such as independent sales organizations (ISOs), use a “sponsoring bank” or other third party to do their payment processing. According to the commenter, it is not clear whether this third party processor is an electronic payment facilitator because the processor does not have a contract with the participating payee. Additionally, this processor generally would only know the net amount of the payment and would not have the information necessary to report the gross amount of the reportable payment transaction. Another commenter suggested defining “electronic payment facilitator” as the party who contracts with a payment settlement entity to “facilitate the settlement (directly or indirectly)” of reportable payment transactions on behalf of the payment settlement entity.

In response to these comments, the final regulations provide that a payment settlement entity (or an electronic payment facilitator acting on behalf of a payment settlement entity) makes a payment in settlement of a reportable payment transaction if the payment settlement entity (or its facilitator) submits the instruction to transfer funds to the account of the participating payee to settle the reportable payment transaction. In cases involving a processor, the processor need not have any agreement or arrangement with the payee to qualify as an electronic payment facilitator. The statute requires only that the facilitator act on behalf of the payment settlement entity. Also, the payment need not come from the processor’s account. The processor need only submit the instruction to transfer funds from the payment settlement entity’s account. If a processor merely prepares payment instructions for the payment settlement entity, which in turn submits these instructions to initiate the transfer of funds, then the processor is not an electronic payment facilitator, and the payment settlement entity retains the reporting obligation. Electronic payment facilitators that do not know the gross amount of each reportable payment transaction are expected to obtain this information from the payment settlement entity. The final regulations include additional examples applying the electronic payment facilitator rule.

A commenter also expressed concern that merchants might only be aware of the merchant acquiring bank or other payment settlement entity and might, therefore, be

confused when receiving statements from the electronic payment facilitator. To address this concern, Form 1099-K, “*Merchant Card and Third Party Payments*,” will include the identifying information of both the payment settlement entity and the electronic payment facilitator. In addition, the payee’s copy of Form 1099-K will describe the entities that are shown on the form.

Participating Payee—Foreign Address Exclusion

Section 6050W(d)(1)(B) provides that, except as provided by the Secretary in regulations or other guidance, the term *participating payee* does not include any person with a foreign address (the “address rule”). The proposed regulations did not exclude persons with foreign addresses from the term participating payee, although the proposed regulations did provide that in many cases a payment settlement entity may rely on a foreign address to avoid reporting. Specifically, the proposed regulations provided that a payment settlement entity that is not a United States (U.S.) payor or U.S. middleman may rely on a foreign address for a participating payee to avoid reporting as long as the payor neither knows nor has reason to know that the payee is a U.S. person. The proposed regulations also provided that a payment settlement entity that is a person described as a U.S. payor or U.S. middleman in §1.6049-5(c)(5) is not required to report payments to payees with a foreign address as long as, prior to payment, the payee has provided the payor with documentation upon which the payor may rely to treat the payment as made to a foreign person in accordance with §1.1441-1(e)(1)(ii).

Commenters expressed concern that the proposed regulations treat U.S. and non-U.S. payors inconsistently and may impose overly burdensome documentation requirements on U.S. payors, and requested that the address rule apply to U.S. and non-U.S. payors alike. Alternatively, commenters requested that documentation and records maintained consistent with section 326 of the USA PATRIOT Act (“Patriot Act”), 31 U.S.C. 5318(l), should satisfy the documentation requirements for U.S. payors under these regulations.

The final regulations do not adopt these recommendations. The final regulations

do not adopt the suggestion that the documentation standards be made consistent with the Patriot Act because the customer identification requirements under the Patriot Act are not intended to identify U.S. taxpayers and do not adequately address the tax administration concerns of section 6050W.

The final regulations also do not extend the address rule to payment settlement entities that are U.S. payors. The Treasury Department and the IRS understand from meeting with affected parties that payment settlement entities do not currently rely solely on an address to identify a participating payee because payment settlement entities have a business interest in verifying the identity of the participating payee due to the credit and reputational risks inherent in payment card transactions. The Treasury Department and the IRS have a similar compliance interest in ensuring that the participating payee’s identity is verified, and applying the address rule generally to payment settlement entities that are U.S. payors does not adequately address those concerns. For example, where a participating payee receives payment from a U.S. person inside the United States or to a U.S. account, the Treasury Department and the IRS believe it is appropriate to require the participating payee to complete a Form W-8BEN (or other appropriate certification) thereby certifying its foreign status and whether the payment constitutes income that is effectively connected with the conduct of a trade or business in the United States, as required under the proposed and final regulations.

To address the concerns of certain commenters regarding the burden that would be involved in re-documenting existing participating payees, however, the final regulations provide a transition rule. For payments made pursuant to contractual obligations entered into before January 1, 2011, a payment settlement entity that is a U.S. payor or middleman may rely on a foreign address as long as the U.S. payor or middleman neither knows nor has reason to know that the payee is a U.S. person. For this limited purpose, a renewal of such a contractual obligation will not result in a new contractual obligation unless there is a material modification of the contractual obligation.

In addition, the final regulations provide a presumption under which a payment settlement entity that is a U.S. payor or middleman making a payment outside the United States to an offshore account (as defined in §1.6049-5(c)(1)) need not report payments to a participating payee with only a foreign address if the name of the participating payee indicates that it is a foreign *per se* corporation listed in §301.7701-2(b)(8)(i) and the payment settlement entity neither knows nor has reason to know that the participating payee is a U. S. person. The final regulations also provide a grace period after account opening to collect documentation by applying the grace period rules of §1.6049-5(d)(2)(ii) if the participating payee has only a foreign address.

Payment settlement entities that are not U.S. payors or middlemen are not required to make a return of information if the participating payee does not have a U.S. address as long as the payment settlement entity does not know or have reason to know that the payee is a U.S. person. Commenters requested additional guidance for situations in which a participating payee has both a foreign address and a U.S. address. Under the final regulations, if the participating payee has any U.S. address, the non-U.S. payment settlement entity may treat the participating payee as a foreign person only if the non-U.S. payment settlement entity has in its files documentation upon which the payment settlement entity may rely to treat the payment as made to a foreign person in accordance with §1.1441-1(e)(1)(ii).

Payments Made in Currencies Other Than the United States Dollar

Several commenters requested that the final regulations provide a rule for the conversion into U.S. dollars of amounts paid in foreign currency. This suggestion was adopted. The final regulations provide that when a payment is made or received in a foreign currency, the U.S. dollar amount is determined by converting such foreign currency into U.S. dollars on the date of the transaction at the spot rate (as defined in §1.988-1(d)(1)) or pursuant to a reasonable spot rate convention, such as a month-end spot rate or a monthly average spot rate.

Duplicate Reporting of the Same Transaction

Section 6050W(g) provides that the Secretary may prescribe regulations or other guidance as necessary or appropriate to carry out section 6050W, including rules to prevent the reporting of the same transaction more than once. The proposed regulations provided that any payment card transaction that otherwise would be reportable under both sections 6041 and 6050W must be reported under section 6050W and not section 6041. Relief from reporting under section 6041 was not provided in the proposed regulations, however, for third party network transactions because these transactions are not subject to reporting under section 6050W unless the *de minimis* threshold (more than 200 transactions aggregating more than \$20,000 per calendar year for a given payee) is met. Nor was relief provided from reporting under section 6050W and other Code sections, including section 3402(t) (relating to withholding on certain payments made by government entities). The proposed regulations requested additional comments regarding the application of a rule to prevent the reporting of the same transaction more than once.

Numerous commenters requested that relief from duplicate reporting under both sections 6050W and 6041 be extended to include third party network transactions. This suggestion was adopted. Accordingly, the final regulations provide that payment card and third party network transactions that otherwise would be reportable under both sections 6041 and 6050W must be reported under section 6050W and not section 6041. The final regulations also provide that, solely for purposes of determining whether a payor is eligible for relief from reporting under section 6041, the *de minimis* threshold for third party network transactions in §1.6050W-1(c)(4) is disregarded because the section 6041 payor will be unable to determine whether the *de minimis* threshold applies.

Commenters also requested relief from duplicate reporting under both sections 6050W and 3402(t). However, commenters have indicated that merchant acquiring banks and other payment settlement entities would have administrative difficulty in determining whether payment

card and third party network transactions will be subject to withholding and reporting under section 3402(t). Therefore, the final regulations do not provide relief for transactions that would otherwise be reported under both sections 6050W and 3402(t). However, the Treasury Department and the IRS are continuing to consider whether relief could be provided under section 3402(t) or section 6050W.

Several commenters requested relief from duplicate reporting of the same transaction under both sections 6050W and 6041A (relating to returns regarding payments of remuneration for services and direct sales). This suggestion was adopted for payment card transactions and third party network transactions subject to section 6041A(a). The final regulations provide that any transaction that would otherwise be reported under both sections 6050W and 6041A(a) must be reported under section 6050W and not section 6041A(a).

Similar relief from duplicate reporting of the same transaction under both sections 6050W and 6041A(b) is not warranted, however, because sections 6050W and 6041A(b) report different types of information and serve different purposes. Section 6041A(b) provides that if any person engaged in a trade or business, in the course of the trade or business during any calendar year, sells \$5,000 or more of consumer goods to any buyer on a buy-sell basis, a deposit-commission basis, or any similar basis, for resale in the home or other than in a permanent retail establishment, that person must file a return reporting the amount of the sales to the buyer during the calendar year. Thus, unlike section 6050W, which requires payors to report information about payments to sellers, section 6041A(b) requires sellers of certain consumer products to report information about payments from buyers. Therefore, the final regulations do not provide relief for transactions that are reportable under both sections 6050W and 6041A(b).

Electronic Consent Procedures

Section 6050W(f) provides that payee statements may be furnished electronically. Prior to the proposed regulations, commenters requested that the existing procedures for payee statements be mod-

ified to eliminate the requirement for an affirmative consent to receive the payee statement under section 6050W electronically. This request was not adopted in the proposed regulations. Instead, additional comments were requested on electronic consent procedures.

Many commenters suggested eliminating the requirement for an affirmative consent to receive the payee statement electronically. Commenters requested that merchants already receiving business communications electronically be deemed to have consented to receive electronic payee statements under section 6050W. Commenters also suggested eliminating the requirement to notify payees about electronic payee statements in a separate communication. Commenters suggested permitting merchants receiving paper communications to consent to electronic payee statements by logging onto a website to indicate their consent, with no further written consent required.

In response to these comments, the final regulations simplify existing electronic consent procedures. Section 1.6050W-2 provides that a recipient consents to receive the statement required under section 6050W in an electronic format either by making an affirmative consent or, in the alternative, by previously having consented to receive from the furnisher other federal tax statements in an electronic format. The consent may be made electronically in any manner that reasonably demonstrates that the recipient can access the statement in the electronic format in which it will be furnished to the recipient. Alternatively, the consent may be made in a paper document if it is confirmed electronically. Section 1.6050W-2 sets forth the procedures for meeting the consent requirements.

Time, Form and Manner for Reporting

Section 6050W(a) provides that the return required under this section shall be made at the time and in the form and manner as required by regulations. The proposed regulations provided that the return required by section 6050W must be made according to the forms and instructions published by the IRS. Form 1099-K, “*Merchant card and third-party payments*,” requires annual reporting, with respect to each participating payee, of the gross amount of the aggregate reportable

payment transactions for the calendar year and the gross amount of the aggregate reportable transactions for each month of the calendar year.

A commenter expressed concern that the requirement for monthly amounts to be reported on Form 1099-K would be burdensome for small businesses and sole proprietors. The final rules retain the proposed rule because the inclusion of monthly amounts on the return filed with the IRS and furnished to the payee will aid in reconciling payment card and third party network transactions for fiscal year payees.

Backup Withholding

The Act amended section 3406(b)(3) to provide that amounts reportable under section 6050W are subject to backup withholding requirements, effective for amounts paid after December 31, 2011. The proposed regulations proposed to amend existing regulations under section 3406 to provide that persons making information returns with respect to any reportable payment under section 6050W made after December 31, 2011, are included in the definition of “payors” obligated to backup withhold.

Section 6050W(d)(1)(C) provides that, for purposes of section 6050W, the definition of *participating payee* includes any governmental unit. The proposed regulations incorporated this statutory provision. One commenter asked whether reportable payments made to governmental units are subject to backup withholding under section 3406(a). The Act amended section 3406(b) to provide that reportable payments subject to information reporting under section 6050W are subject to backup withholding if a condition for backup withholding, as set forth in section 3406(a)(1), exists. The Act, however, did not eliminate any of the existing statutory exceptions to backup withholding. For example, section 3406(g) provides that backup withholding under section 3406(a) shall not apply to any payment made to any organization or governmental unit described in subparagraph (B), (C), (D), (E), or (F) of section 6049(b)(4). The final regulations make no changes to the existing statutory exceptions to backup withholding.

As discussed earlier in this preamble, several commenters stated that defining

“gross amount” as a number that reflects all positive sales transactions on the date of the transaction, without adjustment for any items, may complicate backup withholding, which is generally imposed on the amount of the payment at the time of payment rather than on the amount of the transaction at the time of the transaction. The amount reportable under section 6050W is the gross amount of the transaction on the date of the transaction, which may differ from the amount and date of the payment (potentially a net amount paid on a later date). In response to these comments, the final regulations clarify that the obligation to withhold arises on the date of the transaction. A payor is not required, however, to satisfy its withholding liability until the time that payment is made. The amount withheld is based on the total reportable amount, that is, the gross amount of the transaction.

A commenter stated that on the date of payment, the payee’s account may have insufficient funds available for backup withholding. For example, if sales returns exceed positive sales transactions for the transaction period, a merchant’s account balance could be less than the required amount of backup withholding or even zero. In response to this concern, the final regulations allow backup withholding from an alternate source maintained by the payor for the payee if the payee’s account has insufficient funds. The final regulations further provide that if the payor cannot locate an alternative source of cash from which to backup withhold, the payor may defer its obligation to backup withhold until the earlier of the date on which the payee’s account has sufficient funds or the close of the fourth calendar year after the obligation arose. At the close of the fourth calendar year after the backup withholding obligation arose, if the payor has not located an alternate source from which to backup withhold, and the account has insufficient funds, then the backup withholding obligation will cease to exist.

Finally, the final regulations clarify how to apply the backup withholding rules to third party network transactions, which are subject to a *de minimis* rule. In general, the amount that is subject to withholding under section 3406 is the amount subject to reporting under section 6050W. Section 3406(b)(4) provides that the determination of whether a payment is a reportable pay-

ment for purposes of backup withholding is made without regard to any minimum amount that must be paid before a return is required. Accordingly, the final regulations provide that, in the case of payments made in settlement of third party network transactions, the amount subject to withholding under section 3406 is determined without regard to the exception for *de minimis* payments by third party settlement organizations in section 6050W(e) and the final regulations in this document.

Penalties

The Act amended section 6724(d) by adding returns required by section 6050W to the definition of information return for purposes of penalties for failure to comply with certain reporting requirements. The proposed regulations proposed to amend the regulations to add reportable payments under section 6050W to the list of information returns subject to the penalties under section 6721 (failure to file correct information returns) and section 6722 (failure to furnish correct payee statements). The final regulations adopt these amendments.

Commenters requested that the final regulations specifically waive penalties for persons who have made a reasonable and good faith effort to implement section 6050W reporting and related backup withholding but who fail to comply. This suggestion was not adopted because the existing regulations under section 6724 provide extensive guidance for waiver of penalties due to reasonable cause for failure to file correct information returns and failure to furnish correct payee statements. The IRS will continue to work closely with stakeholders to ensure the smooth implementation of the provisions in these regulations, including, in general, the mitigation of penalties in the early stages of implementation, except for particularly egregious cases.

Effective/Applicability Dates:

The regulations under sections 6041, 6041A, 6050W, 6051, 6721 and 6722 apply to returns for calendar years beginning after December 31, 2010. The regulations under section 3406 apply to amounts paid after December 31, 2011.

Special Analyses

It has been determined that this final rule is not a significant regulatory action as defined in Executive Order 12866. Therefore, a regulatory assessment is not required. It also has been determined that section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to these regulations. Pursuant to the Regulatory Flexibility Act (5 U.S.C. chapter 6), it is hereby certified that the regulations will not have a significant economic impact on a substantial number of small entities. This certification is based on the fact that the persons required to report under section 6050W, payment settlement entities, will generally not be small businesses. Merchant acquiring entities, the payment settlement entities required to report payment card transactions, will primarily be banks with over \$175 million in assets. Third party settlement organizations, the payment settlement entities required to report third party network transactions, will generally not be small entities by virtue of the definition of a third party payment network, which requires the establishment of accounts with a central organization (the third party settlement organization) by a substantial number of persons. Further, section 6050W(e) provides a *de minimis* exception that exempts third party settlement organizations from reporting transactions with respect to a payee if the aggregate amount of such transactions does not exceed \$20,000 or the aggregate number of such transactions does not exceed 200. The Treasury Department and the IRS certify that the regulations in this document will not have a significant economic impact on a substantial number of small entities. Pursuant to section 7805(f) of the Code, the notice of proposed rulemaking preceding these regulations was submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on their impact on small business.

Drafting Information

The principal author of these proposed regulations is Barbara Pettoni, Office of Associate Chief Counsel (Procedure and Administration).

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Adoption of Amendments to the Regulations

Accordingly, 26 CFR parts 1, 31 and 301 are amended as follows:

PART 1—INCOME TAXES

Paragraph 1. The authority citation for part 1 continues to read in part as follows:

Authority: 26 U.S.C. 7805 * * *

Par. 2. Section 1.6041-1 is amended by adding a sentence at the end of paragraph (a)(1)(ii), revising paragraph (j) and adding paragraphs (a)(1)(iv) and (a)(1)(v) to read as follows:

§1.6041-1 Return of information as to payments of \$600 or more.

(a) * * *(1) * * *(i) * * *

(ii) * * * For payment card transactions (as described in §1.6050W-1(b)) and third party network transactions (as defined in §1.6050W-1(c)) required to be reported on information returns required under section 6050W (relating to payment card and third party network transactions), see special rules in §1.6041-1(a)(1)(iv).

* * * * *

(iv) *Information returns required under section 6050W for calendar years beginning after December 31, 2010.* For payments made by payment card (as defined in §1.6050W-1(b)(3)) or through a third party payment network (as defined in §1.6050W-1(c)(3)) after December 31, 2010, that are required to be reported on an information return under section 6050W (relating to payment card and third party network transactions), the following rule applies. Transactions that are described in paragraph (a)(1)(ii) of this section that otherwise would be subject to reporting under both sections 6041 and 6050W are reported under section 6050W and not section 6041. For provisions relating to information reporting for payment card and third party network transactions, see §1.6050W-1. Solely for purposes of this paragraph, the *de minimis* threshold for third party network transactions in §1.6050W-1(c)(4) is disregarded in determining whether the transaction is subject to reporting under section 6050W.

(v) *Examples.* The provisions of paragraph (a)(1)(iv) of this section are illustrated by the following examples:

Example 1. Restaurant owner A, in the course of business, pays \$600 of fixed or determinable income to B, a repairman, by credit card. B is one of a network of unrelated persons that has agreed to accept A's credit card as payment under an agreement that provides standards and mechanisms for settling the transactions between a merchant acquiring bank and the persons who accept the cards. Merchant acquiring bank Y is responsible for making the payment to B. Under paragraph (a)(1)(iv) of this section, A, as payor, is not required to file an information return under section 6041 with respect to the transaction because Y, as the payment settlement entity for the payment card transaction, is required to file an information return under section 6050W.

Example 2. Restaurant owner A, in the course of business, pays \$600 of fixed or determinable income to B, a repairman, through a third party payment network. B is one of a substantial number of persons who have established accounts with Y, a third party settlement organization that provides standards and mechanisms for settling the transactions and guarantees payments to those persons for goods or services purchased through the network. Y is responsible for making the payment to B. Under paragraph (a)(1)(iv) of this section, A, as payor, is not required to file an information return under section 6041 with respect to the transaction because the transaction is a third party network transaction that is subject to reporting under section 6050W. Solely for purposes of determining whether A is eligible for relief from reporting under section 6041, the *de minimis* threshold for third party network transactions in §1.6050W-1(c)(4) is disregarded.

* * * * *

(j) *Effective/applicability date.* The provisions of paragraphs (b),(c),(e), and (f) apply to payments made after December 31, 2002. The provisions of paragraphs (a)(1)(iv) and (a)(1)(v) apply to payments made after December 31, 2010.

Par. 3. Section 1.6041A-1 is amended by adding paragraph (d)(4) to read as follows:

§1.6041A-1 Returns regarding payments of remuneration for services and certain direct sales.

* * * * *

(d) * * *

(4) *Information returns required under section 6050W for calendar years beginning after December 31, 2010.* (i) For payments made by payment card (as defined in §1.6050W-1(b)(3)) or through a third party payment network (as defined in §1.6050W-1(c)(3)) after December 31, 2010, that are required to be reported on an information return under section 6050W (relating to payment card and third party network transactions), the following rule applies. Transactions that otherwise

would be reportable under both sections 6041A(a) and 6050W are reported under section 6050W and not section 6041A(a). For provisions relating to information reporting for payment card transactions and third party network transactions, see §1.6050W-1. Solely for purposes of this paragraph, the *de minimis* threshold for third party network transactions in §1.6050W-1(c)(4) is disregarded in determining whether the transaction is subject to reporting under section 6050W.

(ii) *Examples.* The provisions of paragraph (d)(4) of this section are illustrated by the following examples:

Example 1. Service-recipient A, in the course of its business, pays remuneration of \$600 to service provider B by credit card for services performed by B. B is one of a network of unrelated persons that has agreed to accept A's credit card as payment under an agreement that provides standards and mechanisms for settling the transactions between a merchant acquiring bank and the persons who accept the cards. Merchant acquiring bank Y is responsible for making the payment to B. Under paragraph (d)(4)(i) of this section, A is not required to file an information return under section 6041A(a) with respect to the transaction because Y, as the payment settlement entity for the payment card transaction, is required to file an information return under section 6050W.

Example 2. Service-recipient A, in the course of business, pays \$600 of fixed or determinable income to B, a repairman, through a third party payment network. B is one of a substantial number of persons who have established accounts with Y, a third party settlement organization that provides standards and mechanisms for settling the transactions and guarantees payments to those persons for goods or services purchased through the network. Y is responsible for making the payment to B. Under paragraph (d)(4)(i) of this section, A is not required to file an information return under section 6041A(a) with respect to the transaction because the transaction is a third party network transaction that is subject to reporting under section 6050W. Solely for purposes of determining whether the transaction is subject to reporting under section 6050W, the *de minimis* threshold for third party network transactions in §1.6050W-1(c)(4) is disregarded.

(iii) *Effective/applicability date.* Paragraph (d)(4) of this section applies to payments made by payment card or through a third party payment network after December 31, 2010.

* * * * *

Par. 4. Section 1.6050W-1 is added to read as follows:

§1.6050W-1 Information reporting for payments made in settlement of payment card and third party network transactions.

(a) *In general*—(1) *General rule.* Every payment settlement entity, as defined in paragraph (a)(4) of this section, must file an information return for each calendar year with respect to payments made in settlement of reportable payment transactions, as defined in paragraph (a)(3) of this section, setting forth the following information:

(i) The name, address, and taxpayer identification number (TIN) of each participating payee, as defined in paragraph (a)(5) of this section, to whom one or more payments in settlement of reportable payment transactions are made.

(ii) With respect to each participating payee, the gross amount, as defined in paragraph (a)(6) of this section, of—

(A) The aggregate reportable payment transactions for the calendar year; and

(B) The aggregate reportable payment transactions for each month of the calendar year.

(iii) Any other information required by the form, instructions or current revenue procedures.

(2) *Payments in settlement of reportable payment transactions.* A payment settlement entity, as defined in paragraph (a)(4) of this section (or an electronic payment facilitator, as defined in paragraph (d)(2) of this section), makes a payment in settlement of a reportable payment transaction if the payment settlement entity (or electronic payment facilitator) submits the instruction to transfer funds to the account of the participating payee for purposes of settling the reportable payment transaction.

(3) *Reportable payment transaction.* The term *reportable payment transaction* means any payment card transaction (as defined in paragraph (b)(1) of this section) and any third party network transaction (as defined in paragraph (c)(1) of this section).

(4) *Payment settlement entity*—(i) *Definition.* The term *payment settlement entity* means a domestic or foreign entity that is—

(A) In the case of a payment card transaction, a merchant acquiring entity (as defined in paragraph (b)(2) of this section); and

(B) In the case of a third party network transaction, a third party settlement organization (as defined in paragraph (c)(2) of this section).

(ii) *Multiple payment settlement entities.* If two or more persons qualify as payment settlement entities (as defined in paragraph (a)(4)(i) of this section) with respect to a reportable payment transaction, then only the payment settlement entity that in fact makes payment in settlement of the reportable payment transaction must file the information return required by paragraph (a)(1) of this section.

(5) *Participating payee*—(i) *Definition.* In general, the term *participating payee* means any person, including any governmental unit (and any agency or instrumentality thereof), who:

(A) In the case of a payment card transaction, accepts a payment card (as defined in paragraph (b)(3) of this section) as payment; and

(B) In the case of a third party network transaction, accepts payment from a third party settlement organization (as defined in paragraph (c)(2) of this section) in settlement of such transaction.

(ii) *Foreign payees*—(A) *In general.* For payments pursuant to contractual obligations entered into after December 31, 2010, a payment settlement entity that is a person described as a U.S. payor or U.S. middleman in §1.6049-5(c)(5) is not required to make a return of information for payments to a participating payee with a foreign address as long as, prior to payment, the payment settlement entity has in its files documentation upon which the payment settlement entity may rely to treat the payment as made to a foreign person in accordance with §1.1441-1(e)(1)(ii). For purposes of this paragraph (a)(5)(ii), the provisions of §1.1441-1 shall apply by substituting the term payor for the term withholding agent and without regard to the limitation to amounts subject to withholding under chapter 3 of the Internal Revenue Code and the regulations under that chapter. Such a payment settlement entity need not make a return of information for payments made outside the United States (within the meaning of §1.6049-5(e)) to an offshore account (as defined in §1.6049-5(c)(1)) to a participating payee with only a foreign address if the name of the participating payee indicates that it is an entity listed as a per se

corporation under §301.7701-2(b)(8)(i) and the payment settlement entity does not know or have reason to know that the participating payee is a United States person. A payment settlement entity may apply the grace period rules of §1.6049-5(d)(2)(ii) of the regulations for payments to a participating payee with only a foreign address, without regard to whether the amounts paid are described in §1.1441-6(c)(2) or are reportable under section 6042, 6045, 6049, or 6050N. For payments pursuant to contractual obligations entered into before January 1, 2011, a payment settlement entity that is a person described as a U.S. payor or U.S. middleman in §1.6049-5(c)(5) is not required to make a return of information for payments to a participating payee with a foreign address as long as the payment settlement entity neither knows nor has reason to know that the participating payee is a United States person. For this purpose, a renewal of such a contractual obligation will not result in a new contractual obligation unless there is a material modification to the contractual obligation.

(B) *Non-U.S. payor or middleman.* A payment settlement entity that is not a person described as a U.S. payor or U.S. middleman in §1.6049-5(c)(5) is not required to make a return of information for a payment to a participating payee that does not have a United States address as long as the payment settlement entity neither knows nor has reason to know that the participating payee is a United States person. If the participating payee has any United States address, the payment settlement entity may treat the participating payee as a foreign person only if the payment settlement entity has in its files documentation upon which the payment settlement entity may rely to treat the payment as made to a foreign person in accordance with §1.1441-1(e)(1)(ii).

(C) *Foreign address; United States address.* For purposes of this section, *foreign address* means any address that is not within the United States, as defined in section 7701(a)(9) of the Internal Revenue Code (the States and the District of Columbia). *United States address* means any address that is within the United States.

(6) *Gross amount.* For purposes of this section, *gross amount* means the total dollar amount of aggregate reportable payment transactions for each participat-

ing payee without regard to any adjustments for credits, cash equivalents, discount amounts, fees, refunded amounts or any other amounts. The dollar amount of each transaction is determined on the date of the transaction.

(b) *Payment card transactions*—(1) *Definition.* The term *payment card transaction* means any transaction in which a payment card, or any account number or other indicia associated with a payment card, is accepted as payment.

(2) *Merchant acquiring entity.* The term *merchant acquiring entity* means the bank or other organization that has the contractual obligation to make payment to participating payees (as defined in paragraph (a)(5)(i)(A) of this section) in settlement of payment card transactions.

(3) *Payment card*—(i) The term *payment card* means any card, including any stored-value card as defined in paragraph (b)(4) of this section, issued pursuant to an agreement or arrangement that provides for—

(A) One or more issuers of such cards;

(B) A network of persons unrelated to each other, and to the issuer, who agree to accept such cards as payment; and

(C) Standards and mechanisms for settling the transactions between the merchant acquiring entities and the persons who agree to accept the cards as payment.

(ii) Persons who agree to accept such cards as payment as described in this paragraph (b)(3) are participating payees within the meaning of paragraph (a)(5)(i)(A) of this section.

(4) *Stored-value cards.* The term *stored-value card* means any card with a prepaid value, including any gift card.

(5) *Transactions for which no return of information is required under section 6050W*—(i) *Withdrawals and cash advances.* The use of a “payment card” as defined in paragraph (b)(3) of this section by a cardholder to withdraw funds at an automated teller machine, or to obtain a cash advance or loan against the cardholder’s account, is not a payment card transaction under paragraph (b)(1) of this section because the card is not being accepted as payment by a merchant or other payee.

(ii) *Convenience checks.* The acceptance of a check issued in connection with a payment card account by a merchant or other payee is not a payment card trans-

action under paragraph (b)(1) of this section because the check is accepted and processed through the banking system in the same manner as a traditional check, not as a payment card.

(iii) *Payee related to issuer.* No return of information is required under this section for any transaction in which a payment card within the meaning of paragraph (b)(3) is accepted as payment by a merchant or other payee who is related to the issuer of the payment card.

(c) *Third party network transactions*—(1) *Definition.* The term *third party network transaction* means any transaction that is settled through a third party payment network.

(2) *Third party settlement organization.* The term *third party settlement organization* means the central organization that has the contractual obligation to make payments to participating payees (as defined in paragraph (a)(5)(i)(B) of this section) of third party network transactions. A central organization is a third party settlement organization if it provides a third party payment network (as defined in paragraph (c)(3)(i) of this section) that enables purchasers to transfer funds to providers of goods and services.

(3) *Third party payment network.* (i) The term *third party payment network* means any agreement or arrangement that—

(A) Involves the establishment of accounts with a central organization by a substantial number of providers of goods or services who are unrelated to the organization and who have agreed to settle transactions for the provision of the goods or services to purchasers according to the terms of the agreement or arrangement;

(B) Provides standards and mechanisms for settling the transactions; and

(C) Guarantees payment to the persons providing goods or services in settlement of transactions with purchasers pursuant to the agreement or arrangement.

(ii) A third party payment network does not include any agreement or arrangement that provides for the issuance of payment cards.

(iii) Persons who are providers of goods and services as described in this paragraph (c)(3) are participating payees within the meaning of paragraph (a)(5)(i)(B) of this section.

(4) *Exception for de minimis payments.* A third party settlement organization is required to report any information under paragraph (a)(1) of this section with respect to third party network transactions of any participating payee only if—

(i) The amount that would otherwise be reported under paragraph (a)(1)(ii) of this section with respect to such transactions exceeds \$20,000; and

(ii) The aggregate number of such transactions exceeds 200.

(d) *Special rules*—(1) *Aggregated payees.* If a person receives payments from a payment settlement entity (as defined in paragraph (a)(4) of this section) on behalf of one or more participating payees and distributes such payments to one or more participating payees (as defined in paragraph (a)(5) of this section), the person is treated as:

(i) The participating payee with respect to the payment settlement entity; and

(ii) The payment settlement entity with respect to the participating payees to whom the person distributes payments.

(2) *Electronic payment facilitator.* If a payment settlement entity (as defined in paragraph (a)(4) of this section) contracts with an electronic payment facilitator or other third party to make payments in settlement of reportable payment transactions on behalf of the payment settlement entity, the facilitator must file the annual information return under this section in lieu of the payment settlement entity. The facilitator need not have any agreement or arrangement with the participating payee. Also, the payment need not come from the facilitator's account. The facilitator need only submit instructions to transfer funds to the account of the participating payee in settlement of the reportable payment transaction. The facilitator is liable for any applicable penalties for failure to comply with the information reporting requirements of section 6050W.

(3) *Designations.* The party with the obligation to file the annual information return under this section may designate by written agreement any other person to satisfy the requirements of this section. Thus, notwithstanding the rule in paragraph (d)(2) of this section imposing the obligation to file the annual information return on the electronic payment facilitator in lieu of the payment settlement entity, the payment settlement entity may file

the information return by designation if the parties agree in writing. However, a designation does not relieve the party with the reporting obligation from liability for any reporting failures. The party with the obligation to file the annual information return under this section remains liable for any applicable penalties under sections 6721 and 6722 if the requirements of this section are not satisfied.

(4) *Conversion into United States dollars of amounts paid in foreign currency.* When a payment is made or received in a foreign currency, the U.S. dollar amount shall be determined by converting such foreign currency into U.S. dollars on the date of the transaction at the spot rate (as defined in §1.988-1(d)(1)) or pursuant to a reasonable spot rate convention. For example, a payor may use a month-end spot rate or a monthly average spot rate. A spot rate convention must be used consistently with respect to all non-dollar amounts reported and from year to year. Such convention cannot be changed without the consent of the Commissioner or his or her delegate.

(5) *Unrelated persons.* For purposes of this section, *unrelated* means any person who is not related to another person within the meaning of section 267(b) (providing a list of relationships), including the application of section 267(c) and (e)(3) (providing rules relating to constructive ownership), and section 707(b)(1) (relationships with partnerships).

(e) *Examples.* The following examples illustrate the provisions of this section:

Example 1. Merchant acquiring entity. Customer A purchases goods from merchant B using a credit card issued by Bank X. B is one of a network of unrelated persons that has agreed to accept credit cards issued by X as payment under an agreement that provides standards and mechanisms for settling the transaction between a merchant acquiring bank and the persons who accept the cards. Bank Z is the merchant acquiring bank with the contractual obligation to make payment to B for goods provided to A in this transaction. As defined in paragraph (b)(2) of this section, Z is the merchant acquiring entity that must file the annual information return required under paragraph (a)(1) of this section to report the payment made to settle the transaction for the sale of goods from B to A.

Example 2. Third party settlement organization. (i) Merchant B is one of a substantial number of persons selling goods or services over the Internet that have an account with X, an Internet payment service provider. None of these persons, including B, are related to X, and all have agreed to settle transactions for the sale of goods or services to customers according to the terms of their contracts with X. X has guar-

anteed payment to all of these persons, including B, for the sale of goods or services to customers. Customer A purchases goods from B. A pays X for the goods purchased from B. X, in turn, makes payment to B in settlement of the transaction for the sale of goods from B to A.

(ii) X's arrangement constitutes a third party payment network as defined in paragraph (c)(3) of this section because a substantial number of persons that are unrelated to X, including B, have established accounts with X, and X is contractually obligated to settle transactions for the provision of goods or services by these persons to purchasers. Thus, under paragraph (c)(2) of this section, X is a third party settlement organization and the transaction discussed in this *Example* is a third party network transaction under paragraph (c)(1) of this section. Therefore, X must file the annual information return required under paragraph (a)(1) of this section to report the payment made to B in settlement of the transaction with A provided that X's aggregate payments to B from third party network transactions exceed \$20,000 and the aggregate number of X's transactions with B exceeds 200 (as provided in paragraph (c)(4) of this section).

Example 3. Automated clearinghouse network. A operates an automated clearinghouse ("ACH") network that merely processes electronic payments (such as wire transfers, electronic checks, and direct deposit payments) between buyers and sellers. There are no contractual agreements between A and the sellers for the purpose of permitting the sellers to use the ACH network. Thus, A is not a third party settlement organization under paragraph (c)(2) of this section, the ACH network is not a third party payment network under paragraph (c)(3) of this section, and the electronic payment transactions are not third party network transactions under paragraph (c)(1) of this section. A is not required to file the annual information return required under paragraph (a)(1) of this section.

Example 4. ACH processor. B provides a variety of ACH payment processing services to a large number of merchants, such as converting checks received in payment of bills into ACH transactions. B groups payment transactions into an ACH file and transmits the ACH file into the ACH network on behalf of merchants in order to initiate payment to merchants through the ACH network. B makes payments to the merchants after the ACH network verifies that the customers' accounts have sufficient funds. Because the ACH network is not a third party payment network under paragraph (c)(3) of this section, B cannot be a third party settlement organization with respect to the ACH network. Similarly, because the ACH itself is not a third party settlement organization under paragraph (c)(2) of this section, B cannot be an electronic payment facilitator because B is not acting on behalf of a payment settlement entity. However, B may itself be operating third party payment network under paragraph (c)(3) of this section if B has a separate agreement or arrangement that: involves the establishment of accounts with B by a substantial number of unrelated merchants who provide goods or services and have agreed to settle transactions for the provision of the goods or services pursuant to the agreement or arrangement; provides for standards and mechanisms for settling the transactions; and guarantees persons providing goods or ser-

vices pursuant to such agreement or arrangement that these persons will be paid for providing such goods or services.

Example 5. Gross amount. On Day 1, Customer A uses a payment card to purchase \$100 worth of goods from merchant B. Bank X, the merchant acquiring entity for B, is the party with the contractual obligation to make payment to B in settlement of the transaction. On Day 2, X, after deducting fees of \$2, makes payment of \$98 to settle the transaction for the sale of goods from B to A. Under paragraph (a)(6) of this section, X must report the amount of \$100, the amount of the transaction on Day 1, without any reduction for fees or any other amount, as the gross amount of this reportable payment transaction on the annual information return filed under paragraph (a)(1) of this section.

Example 6. Gift card. (i) Customer A purchases a gift card from Merchant X that may be used only at X and its related network of stores. A purchases the gift card using cash. A gives the gift card to B. B uses the gift card to purchase goods at one of X's stores. The purchase of the gift card by A using cash is not a payment card transaction described in paragraph (b)(1) of this section and, thus, is not required to be reported in a return of information required under paragraph (a)(1) of this section. Under paragraph (b)(3) of this section, the gift card is not a payment card because the gift card is only accepted as payment by persons who are related to the issuer of the gift card and to each other. Therefore, the use of the gift card by B is not required to be reported in a return of information required under paragraph (a)(1) of this section.

(ii) The facts are the same as in paragraph (i), except that B adds value to the gift card using a credit card. The use of the credit card to add value to the gift card is a reportable payment transaction (as defined in paragraph (a)(3) of this section) and must be reported in a return of information under this section by the bank or other organization that has the contractual obligation to make payment to X in settlement of the transaction.

Example 7. Private label card. Bank B issues a card imprinted with Retailer C's logo to cardholder A. The "C-card" is accepted as payment only at C or at stores related (within the meaning of section 267(b), (c) and (e)(3) and, section 707(b)(1)) to C. A uses the card at C to purchase electronics equipment. Under paragraph (b)(3) of this section, the C-card is not a payment card because the card is accepted as payment only within a network of persons who are related to each other. Therefore, the use of the card by A at C is not required to be reported in a return of information required under paragraph (a)(1) of this section.

Example 8. Quasi-private label card. Bank B issues a card to cardholder A. The card, known as an "E-card," is issued by B pursuant to an agreement that provides that the E-card is accepted as payment only within a limited network of merchants that carry electronics equipment. The agreement provides for standards and mechanisms for settling the transactions between the merchants and the merchant acquiring entities. The merchants accepting the E-card as payment are not related (within the meaning of section 267(b), (c) and (e)(3) and section 707(b)(1)) to each other or to B. A uses the card to purchase electronics equipment at F Store, one of the stores within the network of merchants accepting the E-card. Under

paragraph (b)(3) of this section, the E-card is a payment card because the card is issued pursuant to an agreement that provides for a network of persons unrelated to each other, and to the issuer, who agree to accept the card as payment. Therefore, the use of the E-card by A to purchase electronics equipment at F Store must be reported in a return of information required under paragraph (a)(1) of this section.

Example 9. Campus card. (i) University Y issues Student A a card that may be used on campus at various university-owned merchants and at various local merchants unrelated to Y. A uses the card in the university-owned cafeteria to purchase lunch. Under paragraph (b)(5)(iii) of this section, no return of information is required because the card is being accepted as payment by a person who is related to the issuer of the card.

(ii) The facts are the same as in paragraph (i), except that A uses the campus card to purchase lunch at a local restaurant, unrelated to Y, that has agreed to accept the campus card as payment. Under paragraph (b)(3) of this section, the campus card is a payment card in this transaction because the card is accepted as payment by a person that is unrelated to this issuer of the card pursuant to an agreement. Therefore, the use of the card by A in the local restaurant for the purchase of lunch must be reported in a return of information required under paragraph (a)(1) of this section by the bank or other organization that has the contractual obligation to make payment to the restaurant in settlement of the transaction.

Example 10. Mall card. Customer B purchases a card that is issued by shopping mall A. Pursuant to an agreement or arrangement, the card is accepted as payment by various merchants located within the mall, who are unrelated to the issuer of the card and to each other. B uses the card in the mall to purchase goods from merchant C. Under paragraph (b)(3) of this section, the mall card is a payment card because the card is accepted as payment by a network of persons who are unrelated to the issuer of the card and to the other merchants who have agreed to accept the card as payment. Therefore, the use of the mall card by B to purchase goods from merchant C is required to be reported in a return of information required under paragraph (a)(1) of this section.

Example 11. Electronic benefit transactions card. Government Agency A issues benefits electronically to recipients by loading these benefits onto a payment card. Pursuant to an agreement, a network of merchants unrelated to A, and to each other, has agreed to accept the benefits card as payment. A issues a card to B, who uses the card to purchase goods from Merchant C. The card issued by A is a payment card (as defined in paragraph (b)(3) of this section) because the card is accepted as payment by a network of persons that are unrelated to the issuer of the card, and to each other.

The use of the card by B to purchase goods from C must be reported in a return of information required under paragraph (a)(1) of this section.

Example 12. Prepaid telephone card. A purchases a prepaid telephone card from Company X that may be used to make telephone calls using various long-distance providers unrelated to X that have agreed to accept the card as payment. A places a telephone call using the prepaid card as payment for the telephone call. Under paragraph (b)(3) of this section, the prepaid telephone card is a payment card because

the card is accepted as payment by a person that is unrelated to the issuer of the card pursuant to an agreement. Therefore, the use of the prepaid card to make payment for the telephone call must be reported in a return of information required under paragraph (a)(1) of this section by the bank or other organization that has the contractual obligation to make payment to the long distance provider in settlement of the transaction.

Example 13. Transit card. City Z accepts a transit card as payment for use of its mass transit system. The transit card is issued by B, an organization unrelated to Z. A network of persons, including Z, who are unrelated to each other and to B, have agreed to accept the transit card issued by B as payment for transit and for other goods and services. Transit rider X purchases a transit card and uses the card to pay for travel on Z's mass transit system. Under paragraph (b)(3) of this section, the transit card is a payment card because the card is accepted as payment by a person who is one of a network of persons that are unrelated to the issuer of the card, and to each other, and that have agreed to accept the card as payment. Therefore, the use of the transit card by X to pay for transit on Z's mass transit system is a payment card transaction described in paragraph (b)(1) of this section that must be reported in a return of information required under paragraph (a)(1) of this section by the bank or other organization that has the contractual obligation to make payment to Z. Z is the participating payee, described in paragraph (a)(5)(i)(A) of this section, of the payment card transaction.

Example 14. Cash advance. Bank A issues Cardholder B a credit card that is a payment card under paragraph (b)(3) of this section. B uses the card at a local bank to obtain a cash advance. Under paragraph (b)(5)(i) of this section, B's use of the payment card to obtain a cash advance is not a payment card transaction (as defined in paragraph (b)(1) of this section) because the card is not being accepted as payment by a merchant.

Example 15. Withdrawals from automated teller machines. Bank A issues Cardholder B a credit card that is a payment card under paragraph (b)(3) of this section. B uses the card at an automated teller machine to obtain cash. Under paragraph (b)(5)(i) of this section, B's use of the payment card to obtain cash is not a payment card transaction (as defined in paragraph (b)(1) of this section) because the card is not being accepted as payment by a merchant.

Example 16. Convenience checks. Bank A issues Cardholder B a credit card that is a payment card under paragraph (b)(3) of this section. A sends B paper checks imprinted with the account number associated with the credit card. B uses one of the checks to purchase goods from Merchant S. The check is accepted by S and processed through the bank system in the same manner as a traditional check. Under paragraph (b)(5)(ii) of this section, B's use of the convenience check to purchase goods is not a payment card transaction (as defined in paragraph (b)(1) of this section) because the check is accepted and processed as a traditional check, not as a payment card.

Example 17. Healthcare network. Health carrier A operates healthcare network Y. A collects premiums from covered persons pursuant to a plan agreement between A and the covered persons for the cost of membership in Y. Separately, A pays healthcare providers pursuant to provider agreements

to compensate these providers for services rendered to covered persons who are members of Y. A is not a third party settlement organization under paragraph (c)(2) of this section because A does not operate a third party payment network that enables purchasers to transfer funds to providers of goods and services. Therefore, A is not required to file the annual information return required under paragraph (a)(1) of this section.

Example 18. Third party accounts payable. X is a "shared-service" organization that performs accounts payable services for numerous purchasers that are unrelated to X. A substantial number of providers of goods and services have established accounts with X and have agreed to accept payment from X in settlement of their transactions with purchasers. The provider agreement with X includes standards and mechanisms for settling the transactions and guarantees payment to the providers, and the arrangement enables purchasers to transfer funds to providers. Under paragraph (c)(3) of this section, X's accounts payable services constitute a third party payment network, of which X is the third party settlement organization (as defined in paragraph (c)(2) of this section). For each payee, X must file the annual information return required under paragraph (a)(1) of this section to report payments made by X in settlement of accounts payable to that payee if X's aggregate payments to that payee exceed \$20,000 and the aggregate number of transactions with that payee exceeds 200 (as provided in paragraph (c)(4) of this section).

Example 19. Toll collection network. State A charges a toll to vehicles that travel its state highways. The tolling agency for A contracted with organization X to perform its toll collection. X provides an electronic toll collection system that allows the toll facility to record the passage of a vehicle with a transponder affixed to the vehicle. The customer account associated with the transponder is automatically debited for the amount of the toll. The customer funds a balance in the account, which is then depleted as the toll transactions occur. X periodically bills the customer to replenish the account. X then makes payment to A to settle the toll transactions that are recorded by the transponder. X also contracts with a substantial number of other entities unrelated to X that have established accounts with X and have agreed to accept payment using the electronic toll collection system provided by X. X guarantees payment to the entities for all toll transactions that are recorded by the transponders, and the arrangement enables customers to transfer funds to State A and other entities that charge tolls. Under paragraph (c)(3) of this section, X's electronic toll collection system constitutes a third party payment network, of which X is the third party settlement organization (as defined in paragraph (c)(2) of this section). For each payee, including A, X must file the annual information return required under paragraph (a)(1) of this section to report payments made by X in settlement of toll transactions if X's aggregate payments to that payee exceed \$20,000 and the aggregate number of transactions with that payee exceeds 200 (as provided in paragraph (c)(4) of this section).

Example 20. Hotel kiosk. Under a "hotel kiosk" arrangement, Hotel B permits its customers to charge, to their room account, transactions for goods and services at a substantial number of sellers unrelated to

B that operate on B's premises, or on the premises of hotels related to B, and that have established accounts in B's hotel kiosk system. Customers settle their room account with B when they check out, and B in turn settles the hotel kiosk transactions with the unrelated sellers. B guarantees payment to the sellers for these transactions and the arrangement enables customers to transfer funds to the sellers by means of one payment made to the hotel. Under paragraph (c)(3) of this section, B's hotel kiosk system constitutes a third party payment network, of which B is the third party settlement organization (as defined in paragraph (c)(2) of this section). For each payee, B must file the annual information return required under paragraph (a)(1) of this section to report payments made by B in settlement of the hotel kiosk transactions if B's aggregate payments to that payee exceed \$20,000 and the aggregate number of transactions with that payee exceeds 200 (as provided in paragraph (c)(4) of this section).

Example 21. Aggregated payee. Corporation A, acting on behalf of A's independently-owned franchise stores, receives payment from Bank X for credit card sales effectuated at these franchise stores. X, the payment settlement entity (as defined in paragraph (a)(4)(i) of this section), is required under paragraph (d)(1)(i) of this section to report the gross amount of the reportable payment transactions distributed to A (notwithstanding the fact that A does not accept payment cards and would not otherwise be treated as a participating payee). In turn, under paragraph (d)(1)(ii) of this section, A is required to report the gross amount of the reportable payment transactions allocable to each franchise store. X has no reporting obligation under this section with respect to payments made by A to its franchise stores.

Example 22. Electronic payment facilitator. (i) Bank A is a merchant acquiring entity (as defined in paragraph (b)(2) of this section) with the contractual obligation to make payments to participating merchants to settle certain credit card transactions. A enters into a contract with Processor X. Pursuant to this contract, X prepares and submits instructions to move funds from A's account to the accounts of participating merchants to settle credit card transactions. X is making payment on A's behalf in settlement of payment card transactions pursuant to a contract between X and A. Therefore, under paragraph (d)(2) of this section, X is an electronic payment facilitator and must file the information return required under paragraph (a)(1) of this section with respect to credit card transactions settled by X. A has no reporting obligation with respect to payments made by X on A's behalf.

(ii) The facts are the same as in paragraph (i) except that A and X state in their contract that A will file the information return required under paragraph (a)(1) of this section. A may file the information return pursuant to this designation. However, X is liable for any applicable penalties under sections 6721 and 6722 if the reporting requirements of this section are not satisfied.

(iii) The facts are the same as in paragraph (i) except that X merely prepares the instructions to move the funds to the accounts of participating merchants, and the instructions are actually submitted by A. A, not X, is making payment in settlement of payment card transactions. Therefore, A retains the obligation to file the information return required under para-

graph (a)(1) of this section with respect to credit card transactions settled by A.

(f) *Prescribed form.* The return required by paragraph (a)(1) of this section must be made according to the forms and instructions published by the Internal Revenue Service.

(g) *Time and place for filing.* Returns made under this section for any calendar year must be filed on or before February 28th (March 31st if filing electronically) of the following year at the Internal Revenue Service Center location designated in the instructions to the relevant form.

(h) *Time and place for furnishing statement—(1) In general.* Every payment settlement entity required to file a return under this section must also furnish to each participating payee a written statement with the same information (as described in paragraph (h)(2) of this section). The statement must be furnished to the payee on or before January 31st of the year following the calendar year in which the reportable payment is made. If the return of information is not made on magnetic media, this requirement may be satisfied by furnishing to such person a copy of all Forms 1099-K, “*Merchant card and third-party payments*,” or any successor form with respect to such person filed with the Internal Revenue Service Center. The statement will be considered furnished to the payee if it is mailed to the payee’s last known address. The payment settlement entity may furnish the statement electronically in accordance with the rules provided in § 1.6050W-2.

(2) *Information to be shown on statement furnished to payee.* Each written statement furnished under paragraph (h)(1) of this section must include the following information—

(i) The name, address, and phone number (or email address if the statement is furnished electronically) of the information contact of the payment settlement entity.

(ii) With respect to the participating payee, the gross amount of—

(A) The aggregate reportable payment transactions for the calendar year; and

(B) The aggregate reportable payment transactions for each month of the calendar year.

(iii) Any other information required by the form, instructions, or current revenue procedures.

(i) *Cross-reference to penalties.* For provisions relating to the penalty for failure to file timely a correct information return required under section 6050W, see section 6721 and the associated regulations. For provisions relating to the penalty for failure to furnish timely a correct payee statement required under section 6050W(f), see section 6722 and the associated regulations. See section 6724 and the associated regulations for the waiver of a penalty if failure is due to reasonable cause and is not due to willful neglect.

(j) *Effective/applicability date.* The rules in this section apply to returns for calendar years beginning after December 31, 2010.

Par. 5. Section 1.6050W-2 is added to read as follows:

§1.6050W-2 Electronic furnishing of information statements for payments made in settlement of payment card and third party network transactions.

(a) *Electronic furnishing of statements—(1) In general.* A person required by section 6050W to furnish a written statement (furnisher) regarding payments made in settlement of payment card and third party network transactions to the person to whom it is required to be furnished (recipient) may furnish the statement in an electronic format in lieu of a paper format. A furnisher who meets the requirements of paragraphs (a)(2) through (a)(5) of this section is treated as furnishing the required statement.

(2) *Consent—(i) In general.* The recipient must have affirmatively consented to receive the statement required under section 6050W in an electronic format or, in the alternative, have previously consented to receive other federal tax statements in an electronic format from the furnisher. The consent may be made electronically in any manner that reasonably demonstrates that the recipient can access the statement in the electronic format in which it will be furnished to the recipient. Alternatively, the consent may be made in a paper document if it is confirmed electronically. Consents must be kept at all times available for inspection by the Internal Revenue Service. Recipients currently receiving electronic communications from the furnisher may elect to receive the statement required

under section 6050W in a paper document in lieu of an electronic format. The election to receive a paper document may be made by notifying the furnisher electronically or in a paper document.

(ii) *Withdrawal of consent.* The consent requirement of paragraph (a)(2)(i) of this section is not satisfied if the recipient withdraws the consent to receive electronic statements and the withdrawal takes effect before the statement is furnished. The furnisher may provide that a withdrawal of consent takes effect either on the date it is received by the furnisher or on a subsequent date. The furnisher may also provide that a request for a paper statement will be treated as a withdrawal of consent.

(iii) *Change in hardware or software requirements.* If a change in the hardware or software required to access the statement creates a material risk that the recipient will not be able to access the statement, the furnisher must, prior to changing the hardware or software, provide notice to the recipient. The notice must describe the revised hardware and software required to access the statement and inform the recipient that a new consent to receive the statement in the revised electronic format must be provided to the furnisher. After implementing the revised hardware and software, the furnisher must obtain from the recipient, in the manner described in paragraph (a)(2)(i) of this section, a new consent or confirmation of consent to receive the statement electronically.

(iv) *Examples.* The following examples illustrate the rules of this paragraph (a)(2):

Example 1. Recipient R has consented to receive the statements required under section 6041 in electronic format from Furnisher F. F has retained R’s consent and keeps it available for inspection by the IRS. F may furnish to R the statement required under section 6050W in electronic format without securing an affirmative consent from R with respect to the statements required under section 6050W.

Example 2. Recipient R has not consented to receive any electronic federal income tax statements from Furnisher F. F may not furnish to R the statements required under section 6050W unless F first secures from R a consent to receive those statements in electronic format in accordance with the requirements of paragraphs (a)(2) through (a)(5) of this section.

Example 3. Furnisher F sends Recipient R a letter stating that R may consent to receive statements required by section 6050W(f) electronically on a website instead of in a paper format. The letter contains instructions explaining how to consent to receive the statements electronically by accessing the website, downloading the consent document, completing the consent document, and e-mailing the completed con-

sent back to F. The consent document posted on the website uses the same electronic format that F uses to furnish statements electronically. R reads the instructions and submits the consent in the manner provided in the instructions. R has consented to receive the statements electronically in the manner described in paragraph (a)(2)(i) of this section.

Example 4. Furnisher F sends Recipient R an e-mail stating that R may consent to receive statements required by section 6050W(f) electronically instead of in a paper format. The e-mail contains an attachment instructing R how to consent to receive the statements electronically. The e-mail attachment uses the same electronic format that F uses to furnish statements electronically. R opens the attachment, reads the instructions, and submits the consent in the manner provided in the instructions. R has consented to receive the statements electronically in the manner described in paragraph (a)(2)(i) of this section.

Example 5. Furnisher F posts a notice on its website stating that Recipient R may receive statements required by section 6050W(f) electronically instead of in a paper format. The website contains instructions on how R may access a secure web page and consent to receive the statements electronically. By accessing the secure web page and giving consent, R has consented to receive the statements electronically in the manner described in paragraph (a)(2)(i) of this section.

(3) *Required disclosures*—(i) *In general.* Prior to, or at the time of, a recipient's consent, the furnisher must provide to the recipient a clear and conspicuous disclosure statement containing each of the disclosures described in paragraphs (a)(3)(ii) through (a)(3)(viii) of this section.

(ii) *Paper statement.* The recipient must be informed that the statement will be furnished on paper if the recipient does not consent to receive it electronically.

(iii) *Scope and duration of consent.* The recipient must be informed of the scope and duration of the consent. For example, the recipient must be informed whether the consent applies to statements furnished every year after the consent is given until it is withdrawn in the manner described in paragraph (a)(3)(v)(A) of this section or only to the statement required to be furnished on or before the January 31st immediately following the date on which the consent is given.

(iv) *Post-consent request for a paper statement.* The recipient must be informed of any procedure for obtaining a paper copy of the recipient's statement after giving the consent described in paragraph (a)(2)(i) of this section and whether a request for a paper statement will be treated as a withdrawal of consent.

(v) *Withdrawal of consent.* The recipient must be informed that—

(A) The recipient may withdraw a consent by writing (electronically or on paper) to the person or department whose name, mailing address, telephone number, and e-mail address is provided in the disclosure statement;

(B) The furnisher will confirm the withdrawal and the date on which it takes effect in writing (either electronically or on paper); and

(C) A withdrawal of consent does not apply to a statement that was furnished electronically in the manner described in this paragraph (a) before the date on which the withdrawal of consent takes effect.

(vi) *Notice of termination.* The recipient must be informed of the conditions under which a furnisher will cease furnishing statements electronically to the recipient.

(vii) *Updating information.* The recipient must be informed of the procedures for updating the information needed by the furnisher to contact the recipient. The furnisher must inform the recipient of any change in the furnisher's contact information.

(viii) *Hardware and software requirements.* The recipient must be provided with a description of the hardware and software required to access, print, and retain the statement, and the date when the statement will no longer be available on the website.

(4) *Format.* The electronic version of the statement must contain all required information and comply with applicable revenue procedures relating to substitute statements to recipients.

(5) *Notice*—(i) *In general.* If the statement is furnished on a website, the furnisher must notify the recipient that the statement is posted on a website. The notice may be delivered by mail, electronic mail, or in person. The notice must provide instructions on how to access and print the statement. The notice must include the following statement in capital letters, "IMPORTANT TAX RETURN DOCUMENT AVAILABLE." If the notice is provided by electronic mail, the foregoing statement must be on the subject line of the electronic mail.

(ii) *Undeliverable electronic address.* If an electronic notice described in paragraph (a)(5)(i) of this section is returned as undeliverable, and the correct electronic address cannot be obtained from the furnisher's records or from the recipient, then

the furnisher must furnish the notice by mail or in person within 30 days after the electronic notice is returned.

(b) *Effective/applicability date.* The rules in this section apply to returns for calendar years beginning after December 31, 2010.

PART 31—EMPLOYMENT TAXES AND COLLECTION OF INCOME TAX AT SOURCE

Par. 6. The authority citation for part 31 continues to read in part as follows:

Authority: 26 U.S.C. 7805 * * *

Par. 7. Section 31.3406-0 is amended as follows:

1. Entries for §31.3406(b)(3)–5(a), (b), (c), (d), and (e) are added.

2. Entry for §31.3406(g)–1 is amended by adding paragraphs (d), (e), and (f).

The additions read as follows:

§31.3406-0 Outline of the backup withholding regulations.

* * * * *

§31.3406(b)(3)–5 Reportable payments of payment card and third party network transactions.

(a) Payment card and third party network transactions subject to backup withholding.

(b) Amount subject to backup withholding.

(c) Time when payments are considered to be subject to backup withholding.

(d) Backup withholding from an alternate source.

(e) Effective/applicability date.

* * * * *

§31.3406(g)–1 Exception for payments to certain payees and certain other payments.

* * * * *

(d) Reportable payments made to Canadian nonresident alien individuals.

(e) Certain reportable payments made outside the United States by foreign persons, foreign offices of United States banks and brokers, and others.

(f) Special rule for certain payment card transactions.

* * * * *

Par. 8. Section 31.3406(a)–2 is amended by revising paragraph (a) to read as follows:

§31.3406(a)–2 Definition of payors obligated to backup withhold.

(a) *In general.* Payor means the person that is required to make an information return under section 6041, 6041A(a), 6042, 6044, 6045, 6049, 6050A, 6050N, or 6050W with respect to any reportable payment (as described in section 3406(b)), or that is described in paragraph (b) of this section.

* * * * *

Par. 9. Section 31.3406(b)(3)–5 is added to read as follows:

§31.3406(b)(3)–5 Reportable payments of payment card and third party network transactions.

(a) *Payment card and third party network transactions subject to backup withholding.* The gross amount of a reportable transaction that is required to be reported under section 6050W (relating to information reporting for payment card and third party network transactions) is a reportable payment for purposes of section 3406. See §31.6051–4 for the requirement to furnish a statement to the payee if tax is withheld under section 3406.

(b) *Amount subject to backup withholding.* In general, the amount described in paragraph (a) of this section that is subject to withholding under section 3406 is the amount subject to reporting under section 6050W. In the case of payments made in settlement of third party network transactions, the amount subject to withholding under section 3406 is determined without regard to the exception for *de minimis* payments by third party settlement organizations in section 6050W(e) and the associated regulations.

(c) *Time when payments are considered to be subject to backup withholding—(1) In general.* In the case of a payment card or third party network transaction reportable under section 6050W, the obligation to withhold arises on the date of the transaction. A payor is not required, however, to satisfy its withholding liability until the time that payment is made.

(2) *Example.* The provisions of paragraph (c)(1) are illustrated by the following example:

Example. On Day 1, Customer A uses a payment card to purchase \$100 worth of goods from Merchant B. Bank X, the merchant acquiring entity for B, is the party with the contractual obligation to make payment to B in settlement of the transaction. On Day 2, X, after deducting fees of \$2, makes payment of \$98 to settle the transaction for the sale of goods from B to A. Under paragraph (a)(6) of §1.6050W–1, X must report the amount of \$100, the amount of the transaction on Day 1, without any reduction for fees or any other amount, as the gross amount of this reportable payment transaction on the annual information return filed under paragraph (a)(1) of §1.6050W–1. Under paragraph (c)(1) of this section, X's obligation, if any, to backup withhold arises on Day 1, the backup withholding obligation must be satisfied on Day 2, and the amount subject to backup withholding is \$100 (the gross amount of the reportable payment transaction (as defined in paragraph (a)(6) of §1.6050W–1)).

(d) *Backup withholding from an alternate source—(1) In general.* A payor may not withhold under section 3406 from a source maintained by the payor other than the source with respect to which there exists a liability to withhold under section 3406 with respect to the payee. See section 3403 and §31.3403–1, which provide that the payor is liable for the amount required to be withheld regardless of whether the payor withholds.

(2) *Exceptions for backup withholding when there are no funds available—(i) Backup withholding from an alternative source.* In the event there are no funds available in the source with respect to which there exists a liability to withhold under section 3406 with respect to the payee, the payor may withhold under section 3406 from another source maintained by the payee with the payor. The source from which the tax is withheld under section 3406 must be payable to at least one of the persons listed on the account subject to withholding. If the account or source is not payable exclusively to the same person or persons listed on the account subject to withholding under section 3406, then the payor must obtain a written statement from all other persons to whom the account or source is payable authorizing the payor to withhold under section 3406 from the alternative account or source. A payor that elects to withhold under section 3406 from an alternative source may determine the account or source from which the tax is to be withheld, or may allow the payee to designate the alternative source.

(ii) *Deferral of withholding.* If the payor cannot locate, with reasonable care (following procedures substantially similar to those set forth in §31.3406(d)–5(c)(3)(ii)(A) and (B)), an alternative source of cash from which the payor may satisfy its withholding obligation pursuant to paragraph (d)(2)(i) of this section, the payor may defer its obligation to withhold under section 3406 until the earlier of—

(A) The date on which cash, in a sufficient amount to satisfy the obligation in full, is deposited in the account subject to withholding under section 3406; or

(B) The close of the fourth calendar year after the obligation arose.

(iii) *Termination of obligation to backup withhold.* If, at the close of the fourth calendar year after the backup withholding arose, the payor has not located an alternate source of cash from which the payor may satisfy its withholding obligation, and sufficient cash to satisfy the obligation in full has not been deposited in the account subject to withholding under section 3406, then the obligation to backup withhold terminates at the close of the fourth calendar year.

(e) *Effective/applicability date.* The provisions of this section apply to amounts paid after December 31, 2011.

Par. 10. Section 31.3406(d)–1 is amended by revising paragraph (d) to read as follows:

§31.3406(d)–1 Manner required for furnishing a taxpayer identification number.

* * * * *

(d) *Rents, commissions, nonemployee compensation, certain fishing boat operators, and payment card and third party network transactions, etc.—Manner required for furnishing a taxpayer identification number.* For accounts, contracts, or relationships subject to information reporting under section 6041 (relating to information reporting at source on rents, royalties, salaries, etc.), section 6041A(a) (relating to information reporting of payments for nonemployee services), section 6050A (relating to information reporting by certain fishing boat operators), section 6050N (relating to information reporting of payments of royalties), or section 6050W (relating to information reporting

for payment card and third party network transactions), the payee must furnish the payee's taxpayer identification number to the payor either orally or in writing. Except as provided in §31.3406(d)-5, the payee is not required to certify under penalties of perjury that the taxpayer identification number is correct regardless of when the account, contract, or relationship is established.

Par. 11. Section 31.6051-4 is amended by revising paragraph (c)(2) to read as follows:

§31.6051-4 Statement required in case of backup withholding.

* * * * *
(c)* * *

(2) The amount subject to reporting under section 6041, 6041A(a), 6042, 6044, 6045, 6049, 6050A, 6050N, or 6050W whether or not the amount of the reportable payment is less than the amount for which an information return is required. If tax is withheld under section 3406, the statement must show the amount of the payment withheld upon;

* * * * *

PART 301—PROCEDURE AND ADMINISTRATION

Par. 12. The authority citation for part 301 continues to read in part as follows:

Authority: 26 U.S.C. 7805* * *

Par. 13. Section 301.6721-1(g) is amended by:

1. Removing the language “or” at the end of paragraph (g)(3)(xii).

2. Redesignating paragraphs (g)(3)(viii), (g)(3)(ix), (g)(3)(x), (g)(3)(xi), (g)(3)(xii) and (g)(3)(xiii) as (g)(3)(ix), (g)(3)(x), (g)(3)(xi), (g)(3)(xii), (g)(3)(xiii) and (g)(3)(xiv).

3. Adding the language “or” at the end of newly designated paragraph (g)(3)(xiii).

4. Adding new paragraph (g)(3)(viii).

The revisions and additions read as follows:

§301.6721-1 Failure to file correct information returns.

* * * * *
(g)* * * (3)* * *

(viii) Section 6050W (relating to information returns with respect to payments

made in settlement of payment card and third party network transactions (effective for information returns required to be filed for calendar years beginning after December 31, 2010)),

* * * * *

Par. 14. Section 301.6722-1 is amended by:

1. Removing the language “and” at the end of paragraph (d)(2)(xviii).

2. Redesignating paragraphs (d)(2)(xvi), (d)(2)(xvii), (d)(2)(xviii) and (d)(2)(xix) as (d)(2)(xvii), (d)(2)(xviii), (d)(2)(xix) and (d)(2)(xx).

3. Adding new paragraph (d)(2)(xvi).

4. Adding the language “and” at the end of the newly designated paragraph (d)(2)(xix).

The revisions and additions read as follows:

§301.6722-1 Failure to furnish correct payee statements.

* * * * *
(d)* * * (2)* * *

(xvi) Section 6050W (relating to information returns with respect to payments made in settlement of payment card and third party network transactions (effective for information returns required to be filed for calendar years beginning after December 31, 2010), generally the recipient copy),

* * * * *

Steven T. Miller,
*Deputy Commissioner for
Services and Enforcement.*

Approved August 3, 2010.

Michael Mundaca,
*Assistant Secretary
of the Treasury (Tax Policy).*

(Filed by the Office of the Federal Register on August 13, 2010, 8:45 a.m., and published in the issue of the Federal Register for August 16, 2010, 75 F.R. 49821)

Section 9815.—Additional Market Reforms

26 CFR 54.9815-2719T: Internal claims and appeals and external review process (temporary).

T.D. 9494

**DEPARTMENT OF THE
TREASURY
Internal Revenue Service
26 CFR Parts 54 and 602**

**DEPARTMENT OF LABOR
Employee Benefits Security
Administration
29 CFR Part 2590
RIN 1210-AB45**

**DEPARTMENT OF HEALTH
AND HUMAN SERVICES
OCIIO-9993-IFC
45 CFR Part 147
RIN 1210-AB45**

**Interim Final Rules for Group
Health Plans and Health
Insurance Issuers Relating
to Internal Claims and
Appeals and External Review
Processes under the Patient
Protection and Affordable
Care Act**

AGENCIES: Internal Revenue Service, Department of the Treasury; Employee Benefits Security Administration, Department of Labor; Office of Consumer Information and Insurance Oversight, Department of Health and Human Services.

ACTION: Interim final rules with request for comments.

SUMMARY: This document contains interim final regulations implementing the requirements regarding internal claims and appeals and external review processes for group health plans and health insurance coverage in the group and individual markets under the Patient Protection and Affordable Care Act. The regulations will generally affect health insurance issuers; group health plans; and participants, ben-

eficiaries, and enrollees in health insurance coverage and in group health plans. The regulations provide plans and issuers with guidance necessary to comply with the law.

DATES: *Effective date.* These interim final regulations are effective on September 21, 2010.

Comment date. Comments are due on or before September 21, 2010.

Applicability dates. These interim final regulations generally apply to group health plans and group health insurance issuers for plan years beginning on or after September 23, 2010. These interim final regulations generally apply to individual health insurance issuers for policy years beginning on or after September 23, 2010.

ADDRESSES: Written comments may be submitted to any of the addresses specified below. Any comment that is submitted to any Department will be shared with the other Departments. Please do not submit duplicates.

All comments will be made available to the public. **WARNING:** Do not include any personally identifiable information (such as name, address, or other contact information) or confidential business information that you do not want publicly disclosed. All comments are posted on the Internet exactly as received, and can be retrieved by most Internet search engines. No deletions, modifications, or redactions will be made to the comments received, as they are public records. Comments may be submitted anonymously.

Department of Labor. Comments to the Department of Labor, identified by RIN 1210-AB45, by one of the following methods:

- *Federal eRulemaking Portal:* <http://www.regulations.gov>. Follow the instructions for submitting comments.
- *Email:* E-OHPSA2719.EBSA@dol.gov.
- *Mail or Hand Delivery:* Office of Health Plan Standards and Compliance Assistance, Employee Benefits Security Administration, Room N-5653, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210, *Attention:* RIN 1210-AB45.

Comments received by the Department of Labor will be posted without change to <http://www.regulations.gov> and <http://www.dol.gov/ebsa>, and available for public inspection at the Public Disclosure Room, N-1513, Employee Benefits Security Administration, 200 Constitution Avenue, NW, Washington, DC 20210.

Department of Health and Human Services. In commenting, please refer to file code OCIO-9993-IFC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to <http://www.regulations.gov>. Follow the instructions under the "More Search Options" tab.

2. *By regular mail.* You may mail written comments to the following address ONLY:

Office of Consumer Information and Insurance Oversight
Department of Health and Human Services,
Attention: OCIO-9993-IFC,
P.O. Box 8016,
Baltimore, MD 21244-1850.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address ONLY:

Office of Consumer Information and Insurance Oversight,
Department of Health and Human Services,
Attention: OCIO-9993-IFC,
Mail Stop C4-26-05,
7500 Security Boulevard,
Baltimore, MD 21244-1850.

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments before the close of the comment period to either of the following addresses:

a. For delivery in Washington, DC—

Office of Consumer Information and Insurance Oversight,
Department of Health and Human Services,
Room 445-G, Hubert H. Humphrey Building,
200 Independence Avenue, SW,
Washington, DC 20201

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the OCIO drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD—

Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
7500 Security Boulevard,
Baltimore, MD 21244-1850

If you intend to deliver your comments to the Baltimore address, please call (410) 786-7195 in advance to schedule your arrival with one of our staff members.

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

Submission of comments on paperwork requirements. You may submit comments on this document's paperwork requirements by following the instructions at the end of the "Collection of Information Requirements" section in this document.

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following website as soon as possible after they have been received: <http://www.regulations.gov>. Follow the search instructions on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning ap-

proximately three weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. EST. To schedule an appointment to view public comments, phone 1-800-743-3951.

Internal Revenue Service. Comments to the IRS, identified by REG-125592-10, by one of the following methods:

- *Federal eRulemaking Portal:* <http://www.regulations.gov>. Follow the instructions for submitting comments.
- *Mail:* CC:PA:LPD:PR (REG-125592-10), room 5205, Internal Revenue Service, P.O. Box 7604, Ben Franklin Station, Washington, DC 20044.
- *Hand or courier delivery:* Monday through Friday between the hours of 8 a.m. and 4 p.m. to: CC:PA:LPD:PR (REG-125592-10), Courier's Desk, Internal Revenue Service, 1111 Constitution Avenue, NW, Washington DC 20224.

All submissions to the IRS will be open to public inspection and copying in room 1621, 1111 Constitution Avenue, NW, Washington, DC from 9 a.m. to 4 p.m.

FOR FURTHER INFORMATION CONTACT: Amy Turner or Beth Baum, Employee Benefits Security Administration, Department of Labor, at (202) 693-8335; Karen Levin, Internal Revenue Service, Department of the Treasury, at (202) 622-6080; Ellen Kuhn, Office of Consumer Information and Insurance Oversight, Department of Health and Human Services, at (301) 492-4100.

Customer Service Information: Individuals interested in obtaining information from the Department of Labor concerning employment-based health coverage laws may call the EBSA Toll-Free Hotline at 1-866-444-EBSA (3272) or visit the Department of Labor's website (<http://www.dol.gov/ebsa>). In addition, information from HHS on pri-

vate health insurance for consumers can be found on the Centers for Medicare & Medicaid Services (CMS) website (http://www.cms.hhs.gov/HealthInsReformforConsume/01_Overview.asp) and information on health reform can be found at <http://www.healthreform.gov>.

SUPPLEMENTARY INFORMATION:

I. Background

The Patient Protection and Affordable Care Act (the Affordable Care Act), Pub. L. 111-148, was enacted on March 23, 2010; the Health Care and Education Reconciliation Act (the Reconciliation Act), Pub. L. 111-152, was enacted on March 30, 2010. The Affordable Care Act and the Reconciliation Act reorganize, amend, and add to the provisions of part A of title XXVII of the Public Health Service Act (PHS Act) relating to group health plans and health insurance issuers in the group and individual markets. The term "group health plan" includes both insured and self-insured group health plans.¹ The Affordable Care Act adds section 715(a)(1) to the Employee Retirement Income Security Act (ERISA) and section 9815(a)(1) to the Internal Revenue Code (the Code) to incorporate the provisions of part A of title XXVII of the PHS Act into ERISA and the Code, and make them applicable to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans. The PHS Act sections incorporated by this reference are sections 2701 through 2728. PHS Act sections 2701 through 2719A are substantially new, though they incorporate some provisions of prior law. PHS Act sections 2722 through 2728 are sections of prior law renumbered, with some, mostly minor, changes.

Subtitles A and C of title I of the Affordable Care Act amend the requirements of title XXVII of the PHS Act (changes to which are incorporated into ERISA section 715). The preemption provisions of ERISA section 731 and PHS Act section 2724² (implemented in 29 CFR 2590.731(a) and 45 CFR 146.143(a)) apply so that the requirements of part 7 of

ERISA and title XXVII of the PHS Act, as amended by the Affordable Care Act, are not to be "construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group or individual health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement" of the Affordable Care Act. Accordingly, State laws that impose on health insurance issuers requirements that are stricter than those imposed by the Affordable Care Act will not be superseded by the Affordable Care Act.

The Departments of Health and Human Services, Labor, and the Treasury (the Departments) are issuing regulations in several phases implementing the revised PHS Act sections 2701 through 2719A and related provisions of the Affordable Care Act. The first phase in this series was the publication of a Request for Information relating to the medical loss ratio provisions of PHS Act section 2718, published in the **Federal Register** on April 14, 2010 (75 FR 19297). The second phase was interim final regulations implementing PHS Act section 2714 (requiring dependent coverage of children to age 26), published in the **Federal Register** on May 13, 2010 (T.D. 9482, 2010-22 I.R.B. 698 [75 FR 27122]). The third phase was interim final regulations implementing section 1251 of the Affordable Care Act (relating to status as a grandfathered health plan), published in the **Federal Register** on June 17, 2010 (T.D. 9489, 2010-29 I.R.B. 55 [75 FR 34538]). The fourth phase was interim final regulations implementing PHS Act sections 2704 (prohibiting preexisting condition exclusions), 2711 (regarding lifetime and annual dollar limits on benefits), 2712 (regarding restrictions on rescissions), and 2719A (regarding patient protections), published in the **Federal Register** on June 28, 2010 (T.D. 9491, 2010-32 I.R.B. 186 [75 FR 37188]). The fifth phase was interim final regulations implementing PHS Act section 2713 (regarding preventive health services), published in the **Federal Regis-**

¹ The term "group health plan" is used in title XXVII of the PHS Act, part 7 of ERISA, and chapter 100 of the Code, and is distinct from the term "health plan," as used in other provisions of title I of the Affordable Care Act. The term "health plan" does not include self-insured group health plans.

² Code section 9815 incorporates the preemption provisions of PHS Act section 2724. Prior to the Affordable Care Act, there were no express preemption provisions in chapter 100 of the Code.

ter on July 19, 2010 (T.D. 9493, 2010–35 I.R.B. 273 [75 FR 41726]). These interim final regulations are being published to implement PHS Act section 2719, relating to internal claims and appeals and external review processes. PHS Act section 2719 is generally effective for plan years (in the individual market, policy years) beginning on or after September 23, 2010, which is six months after the March 23, 2010 date of enactment of the Affordable Care Act. The implementation of other provisions of PHS Act sections 2701 through 2719A will be addressed in future regulations.

II. Overview of the Regulations: PHS Act Section 2719, Internal Claims and Appeals and External Review Processes (26 CFR 54.9815–2719T, 29 CFR 2590.715–27109, 45 CFR 147.136)

a. Scope and definitions

These interim final regulations set forth rules implementing PHS Act section 2719 for internal claims and appeals and external review processes for group health plans and health insurance coverage; these requirements do not apply to grandfathered health plans under section 1251 of the Affordable Care Act. With respect to internal claims and appeals processes for group health coverage, PHS Act section 2719 provides that plans and issuers must initially incorporate the internal claims and appeals processes set forth in 29 CFR 2560.503–1 and update such processes in accordance with standards established by the Secretary of Labor. Similarly, with respect to internal claims and appeals processes for individual health insurance coverage, issuers must initially incorporate the internal claims and appeals processes set forth in applicable State law and update such processes in accordance with standards established by the Secretary of Health and Human Services. These interim final regulations provide such updated standards for compliance. The Department of Labor is also considering further updates to 29 CFR 2560.503–1 and expects to issue future regulations that will propose additional, more comprehensive updates to the standards for plan internal claims and appeals processes.

With respect to external review, PHS Act section 2719 provides a system for applicability of either a State external re-

view process or a Federal external review process. These regulations provide rules for determining which process applies, as well as guidance regarding each process. Consistent with the statutory structure, these interim final regulations adopt an approach that builds on applicable State external review processes. For plans and issuers subject to existing State external review processes, the regulations include a transition period until July 1, 2011. During this period, the State process applies and the Departments will work individually with States on an ongoing basis to assist in making any necessary changes to incorporate additional consumer protections so that the State process will continue to apply after the end of the transition period. For plans and issuers not subject to an existing State external review process (including self-insured plans), a Federal process will apply for plan years (in the individual market, policy years) beginning on or after September 23, 2010. The Departments will be issuing more guidance in the near future on the Federal external review process.

These interim final regulations also set forth rules related to the form and manner of providing notices in connection with internal claims and appeals and external review processes. The regulations also reiterate and preserve the Departments' authority, pursuant to PHS Act section 2719(c), to deem external review processes in operation on March 23, 2010, to be in compliance with the requirements of PHS Act section 2719, either permanently or temporarily.

Paragraph (a)(2) of 26 CFR 54.9815–2719T, 29 CFR 2590.715–2719, 45 CFR 147.136 sets forth definitions relevant for these interim final regulations, including the definitions of an adverse benefit determination and a final internal adverse benefit determination. An adverse benefit determination is defined by incorporating the definition under the Department of Labor's regulations governing claims procedures at 29 CFR 2560.503–1 (DOL claims procedure regulation), and also includes a rescission of coverage. A final internal adverse benefit determination is the upholding of an adverse benefit determination at the conclusion of the internal appeals process or an adverse benefit determination with

respect to which the internal appeals process has been deemed exhausted.

b. Internal claims and appeals process

Paragraph (b) of 26 CFR 54.9815–2719T, 29 CFR 2590.715–2719, 45 CFR 147.136 requires group health plans and health insurance issuers offering group or individual health insurance coverage to implement an effective internal claims and appeals process. The regulations set forth separate rules for group health coverage and individual health insurance coverage.

1. Group health plans and health insurance issuers offering group health insurance coverage

A group health plan and a health insurance issuer offering group health insurance coverage must comply with all the requirements applicable to group health plans under the DOL claims procedure regulation. Therefore, for purposes of compliance with these interim final regulations, a health insurance issuer offering health insurance coverage in connection with a group health plan is subject to the DOL claims procedure regulation to the same extent as if it were a group health plan.

These interim final regulations also set forth six new requirements in addition to those in the DOL claims procedure regulation.

First, for purposes of these interim final regulations, the definition of an adverse benefit determination is broader than the definition in the DOL claims procedure regulation, in that an adverse benefit determination for purposes of these interim final regulations also includes a rescission of coverage. By referencing the DOL claims procedure regulation, an adverse benefit determination eligible for internal claims and appeals processes under these interim final regulations includes a denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make a payment that is based on:

- A determination of an individual's eligibility to participate in a plan or health insurance coverage;

- A determination that a benefit is not a covered benefit;
- The imposition of a preexisting condition exclusion, source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits; or
- A determination that a benefit is experimental, investigational, or not medically necessary or appropriate.

A denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit can include both pre-service claims (for example, a claim resulting from the application of any utilization review), as well as post-service claims. Failure to make a payment in whole or in part includes any instance where a plan pays less than the total amount of expenses submitted with regard to a claim, including a denial of part of the claim due to the terms of a plan or health insurance coverage regarding copayments, deductibles, or other cost-sharing requirements.³ Under these interim final regulations, an adverse benefit determination also includes any rescission of coverage as defined in the regulations restricting rescissions (26 CFR 54.9815–2712T(a)(2), 29 CFR 2590.715–2712(a)(2), and 45 CFR 147.128(a)(2)), whether or not there is an adverse effect on any particular benefit at that time. The regulations restricting rescissions generally define a rescission as a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage. Rescissions of coverage must also comply with the requirements of the regulations restricting rescissions.⁴

Second, these interim final regulations provide that a plan or issuer must notify a claimant of a benefit determination (whether adverse or not) with respect to a claim involving urgent care (as defined in the DOL claims procedure regulation)⁵ as soon as possible, taking into account the medical exigencies, but not later than 24 hours after the receipt of the claim by the plan or health insurance coverage, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan or health insurance coverage.⁶ This is a change from the requirements of the DOL claims procedure regulation, which generally requires a determination not later than 72 hours after receipt of the claim by a group health plan for urgent care claims. The Departments expect that electronic communication will enable faster decision-making today than in the year 2000, when the final DOL claims procedure regulation was issued.

Third, these interim final regulations provide additional criteria to ensure that a claimant receives a full and fair review. Specifically, in addition to complying with the requirements of the DOL claims procedure regulation, the plan or issuer must provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the plan or issuer (or at the direction of the plan or issuer) in connection with the claim.⁷ Such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give the claimant a reasonable opportunity to respond prior to that date. Additionally, before the plan or issuer can issue an adverse benefit determination on review based on a new or additional ratio-

nale, the claimant must be provided, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give the claimant a reasonable opportunity to respond prior to that date.

Fourth, these interim final regulations provide new criteria with respect to avoiding conflicts of interest. The plan or issuer must ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support a denial of benefits. For example, a plan or issuer cannot provide bonuses based on the number of denials made by a claims adjudicator. Similarly, a plan or issuer cannot contract with a medical expert based on the expert's reputation for outcomes in contested cases, rather than based on the expert's professional qualifications.

Fifth, these interim final regulations provide new standards regarding notice to enrollees. Specifically, the statute and these interim final regulations require a plan or issuer to provide notice to enrollees, in a culturally and linguistically appropriate manner (standards for which are described later in this preamble). Plans and issuers must comply with the requirements of paragraphs (g) and (j) of the DOL claims procedure regulation, which detail requirements regarding the issuance of a notice of adverse benefit determination.⁸ Moreover, for purposes of these interim final regulations, additional content re-

³ See the Department of Labor's Frequently Asked Questions (FAQs) About the Benefit Claims Procedure Regulations, FAQ C–12, at www.dol.gov/ebsa.

⁴ These regulations generally provide that a plan or issuer must not rescind coverage with respect to an individual once the individual is covered, except in the case of an act, practice, or omission that constitutes fraud, or an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage.

⁵ Under the DOL claims procedure regulation, a "claim involving urgent care" is a claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

⁶ In the case of a failure to provide sufficient information, under the DOL claims procedure regulation the claimant must be notified as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information necessary to complete the claim. The claimant must be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information.

⁷ This language underscores and is not inconsistent with the scope of the disclosure requirement under the existing Department of Labor claims procedure regulation. That is, the Department of Labor interprets 29 USC 1133 and the DOL claims procedure regulation as already requiring that plans provide claimants with new or additional evidence or rationales upon request and an opportunity to respond in certain circumstances. See Brief of amicus curiae Secretary of the United States Department of Labor, *Midgett v. Washington Group International Long Term Disability Plan*, 561 F.3d 887 (8th Cir. 2009) (No.08–2523) (expressing disagreement with cases holding that there is no such requirement).

⁸ Paragraph (g) of the DOL claims procedure regulation requires that the notice must be written in a manner calculated to be understood by the claimant and generally must include any specific reasons for the adverse determination, reference to the specific provision on which the determination is based, a description of any additional information required to perfect the claim, and a description of the internal appeal process. Paragraph (i) of the DOL claims procedure regulation requires that the notice must also be provided in accordance with specified timeframes for urgent care claims, pre-service claims, and post-service claims.

quirements apply for these notices. A plan or issuer must ensure that any notice of adverse benefit determination or final internal adverse benefit determination includes information sufficient to identify the claim involved. This includes the date of service, the health care provider, and the claim amount (if applicable)⁹, as well as the diagnosis code (such as an ICD-9 code, ICD-10 code, or DSM-IV code)¹⁰, the treatment code (such as a CPT code)¹¹, and the corresponding meanings of these codes. A plan or issuer must also ensure that the reason or reasons for the adverse benefit determination or final internal adverse benefit determination includes the denial code (such as a CARC and RARC)¹² and its corresponding meaning. It must also include a description of the plan's or issuer's standard, if any, that was used in denying the claim (for example, if a plan applies a medical necessity standard in denying a claim, the notice must include a description of the medical necessity standard). In the case of a notice of final internal adverse benefit determination, this description must include a discussion of the decision. Additionally, the plan or issuer must provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal. Finally, the plan or issuer must disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793 to assist enrollees with the internal claims and appeals and external review processes. The Departments intend to issue model notices that could be used to satisfy all the notice requirements under these interim final regulations in the very near future. These notices will be made available at <http://www.dol.gov/ebsa> and <http://www.hhs.gov/ociio/>.

Sixth, these interim final regulations provide that, in the case of a plan or issuer that fails to strictly adhere to all the requirements of the internal claims and ap-

peals process with respect to a claim, the claimant is deemed to have exhausted the internal claims and appeals process, regardless of whether the plan or issuer asserts that it substantially complied with these requirements or that any error it committed was *de minimis*. Accordingly, upon such a failure, the claimant may initiate an external review and pursue any available remedies under applicable law, such as judicial review.

In addition to the six new requirements, the statute and these interim final regulations require a plan and issuer to provide continued coverage pending the outcome of an internal appeal. For this purpose, the plan or issuer must comply with the requirements of the DOL claims procedure regulation, which, as applied under these interim final regulations, generally prohibits a plan or issuer from reducing or terminating an ongoing course of treatment without providing advance notice and an opportunity for advance review. Additionally, individuals in urgent care situations and individuals receiving an ongoing course of treatment may be allowed to proceed with expedited external review at the same time as the internal appeals process, under either a State external review process or the Federal external review process, in accordance with the Uniform Health Carrier External Review Model Act promulgated by the National Association of Insurance Commissioners (NAIC Uniform Model Act). The provision of the NAIC Uniform Model Act requiring simultaneous internal appeals and external review is discussed later in this preamble.

2. Health insurance issuers offering individual health insurance coverage

The statute requires the Secretary of Health and Human Services to set forth processes for internal claims and appeals in the individual market. Under these interim final regulations, the Secretary of Health and Human Services has determined that a health insurance issuer

offering individual health insurance coverage must generally comply with all the requirements for the internal claims and appeals process that apply to group health coverage.¹³ The process and protections of the group health coverage standards are also pertinent to the individual health insurance market. Furthermore, many issuers in the individual market also provide coverage in the group market. To facilitate compliance, it is preferable to have similar processes in the group and individual markets. Accordingly, an individual health insurance issuer is subject to the DOL claims procedure regulation as if the issuer were a group health plan. Moreover, an individual health insurance issuer must also comply with the additional standards in these interim final regulations imposed on group health insurance coverage.

To address certain relevant differences in the group and individual markets, health insurance issuers offering individual health insurance coverage must comply with three additional requirements. First, these interim final regulations expand the scope of the group health coverage internal claims and appeals process to cover initial eligibility determinations for individual health insurance coverage. This protection is important because eligibility determinations in the individual market are frequently based on the health status of the applicant, including preexisting conditions. With the prohibition against preexisting condition exclusions taking effect for policy years beginning on or after September 23, 2010 for children under 19 and for all others for policy years beginning on or after January 1, 2014, applicants in the individual market should have the opportunity for a review of a denial of eligibility of coverage to determine whether the issuer is complying with the new provisions in making the determination.

Second, although the DOL claims procedure regulation permits plans to have a second level of internal appeals, these interim final regulations require that

⁹ The amount of the claim may not be knowable or available at the time, such as in a case of preauthorization, or there may be no specific claim, such as in a case of rescission.

¹⁰ ICD-9 and ICD-10 codes refer to the International Classification of Diseases, 9th revision and 10th revision, respectively. The DSM-IV codes refer to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition.

¹¹ CPT refers to Current Procedural Terminology.

¹² CARC refers to Claim Adjustment Reason Code and RARC refers to Remittance Advice Remark Code.

¹³ The special rules in the DOL claims procedure regulation applicable only to multiemployer plans (generally defined in section 3(37) of ERISA as plans maintained pursuant to one or more collective bargaining agreements for the employees of two or more employers) do not apply to health insurance issuers in the individual market.

health insurance issuers offering individual health insurance coverage have only one level of internal appeals. This allows the claimant to seek either external review or judicial review immediately after an adverse benefit determination is upheld in the first level of the internal appeals process. There is no need for a second level of an internal appeal in the individual market since the issuer conducts all levels of the internal appeal, unlike in the group market, where a third party administrator may conduct the first level of the internal appeal and the employer may conduct a second level of the internal appeal. Accordingly, after an issuer has reviewed an adverse benefit determination once, the claimant should be allowed to seek external review of the determination by an outside entity.

Finally, these interim final regulations require health insurance issuers offering individual health insurance coverage to maintain records of all claims and notices associated with their internal claims and appeals processes. The records must be maintained for at least six years, which is the same requirement for group health plans under the ERISA recordkeeping requirements. An issuer must make such records available for examination upon request. Accordingly, a claimant or State or Federal agency official generally would be able to request and receive such documents free of charge. Other Federal and State law regarding disclosure of personally identifiable health information may apply, including the HIPAA privacy rule.¹⁴

c. State standards for external review

The statute and these interim final regulations provide that plans and issuers must comply with either a State external review process or the Federal external review process. These interim final regulations provide a basis for determining when plans and issuers must comply with an applicable State external review process and when they must comply with the Federal external review process.

For health insurance coverage, if a State external review process that applies to and is binding on an issuer includes,

at a minimum, the consumer protections in the NAIC Uniform Model Act in place on July 23, 2010,¹⁵ then the issuer must comply with the applicable State external review process and not with the Federal external review process. In such a case, to the extent that benefits under a group health plan are provided through health insurance coverage, the issuer is required to satisfy the obligation to provide an external review process, so the plan itself is not required to comply with either the State external review process or the Federal external review process. The Departments encourage States to establish external review processes that meet the minimum consumer protections of the NAIC Uniform Model Act. The Departments prefer having States take the lead role in regulating health insurance issuers, with Federal enforcement only as a fallback measure.

These interim final regulations do not preclude a State external review process from applying to and being binding on a self-insured group health plan under some circumstances. While the preemption provisions of ERISA ordinarily would prevent a State external review process from applying directly to an ERISA plan, ERISA preemption does not prevent a State external review process from applying to some self-insured plans, such as nonfederal governmental plans and church plans not covered by ERISA preemption, and multiple employer welfare arrangements, which can be subject to both ERISA and State insurance laws. A State external review process could apply to such plans if the process includes, at a minimum, the consumer protections in the NAIC Uniform Model Act.

Under these interim final regulations, any plan or issuer not subject to a State external review process must comply with the Federal external review process. (However, to the extent a plan provides health insurance coverage that is subject to an applicable State external review process that provides the minimum consumer protections in the NAIC Uniform Model Act, the plan does not have to comply with the Federal external review process.) A plan or issuer is subject to the Federal external review process where the State

external review process does not meet, at a minimum, the consumer protections in the NAIC Uniform Model Act, as well as where there is no applicable State external review process.

For a State external review process to apply instead of the Federal external review process, the Affordable Care Act provides that the State external review process must include, at a minimum, the consumer protections of the NAIC Uniform Model Act. Accordingly, the Departments have determined that the following elements from the NAIC Uniform Model Act are the minimum consumer protections that must be included for a State external review process to apply. The State process must:

- Provide for the external review of adverse benefit determinations (and final internal adverse benefit determinations) that are based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.
- Require issuers to provide effective written notice to claimants of their rights in connection with an external review for an adverse benefit determination.
- To the extent the State process requires exhaustion of an internal claims and appeals process, make exhaustion unnecessary if: the issuer has waived the exhaustion requirement, the claimant has exhausted (or is considered to have exhausted) the internal claims and appeals process under applicable law, or the claimant has applied for expedited external review at the same time as applying for an expedited internal appeal.
- Provide that the issuer against which a request for external review is filed must pay the cost of an independent review organization (IRO) for conducting the external review. While having the issuer pay the cost of the IRO's review is reflected in the NAIC Uniform Model Act, if the State pays this cost, the Departments would treat the State process as meeting this requirement; this alternative is just as protective to the consumer because the cost of the

¹⁴ See 45 CFR §164.500 *et seq.*

¹⁵ These interim final regulations specify that the relevant NAIC Uniform Model Act is the version in place on the date these interim final regulations are published. If the NAIC Uniform Model Act is later modified, the Departments will review the changes and determine to what extent any additional requirements will be incorporated into the minimum standards for State external review processes by amending these regulations. This version of the NAIC Uniform Model Act is available at <http://www.dol.gov/ebsa> and <http://www.hhs.gov/ociio/>.

review is not imposed on the consumer. Notwithstanding this requirement that the issuer (or State) must pay the cost of the IRO's review, the State process may require a nominal filing fee from the claimant requesting an external review. For this purpose, to be considered nominal, a filing fee must not exceed \$25, it must be refunded to the claimant if the adverse benefit determination is reversed through external review, it must be waived if payment of the fee would impose an undue financial hardship, and the annual limit on filing fees for any claimant within a single year must not exceed \$75.

- Not impose a restriction on the minimum dollar amount of a claim for it to be eligible for external review (for example, a \$500 minimum claims threshold).
- Allow at least four months after the receipt of a notice of an adverse benefit determination or final internal adverse benefit determination for a request for an external review to be filed.
- Provide that an IRO will be assigned on a random basis or another method of assignment that assures the independence and impartiality of the assignment process (for example, rotational assignment) by a State or independent entity, and in no event selected by the issuer, plan, or individual.
- Provide for maintenance of a list of approved IROs qualified to conduct the review based on the nature of the health care service that is the subject of the review. The State process must provide for approval only of IROs that are accredited by a nationally recognized private accrediting organization.
- Provide that any approved IRO has no conflicts of interest that will influence its independence.
- Allow the claimant to submit to the IRO in writing additional information that the IRO must consider when conducting the external review and require that the claimant is notified of such right to do so. The process must also require that any additional information submitted by the claimant to the IRO must be forwarded to the issuer within one business day of receipt by the IRO.
- Provide that the decision is binding on the plan or issuer, as well as the claimant, except to the extent that other

remedies are available under State or Federal law.

- Provide that, for standard external review, within no more than 45 days after the receipt of the request for external review by the IRO, the IRO must provide written notice to the issuer and the claimant of its decision to uphold or reverse the adverse benefit determination.
- Provide for an expedited external review in certain circumstances and, in such cases, the State process must provide notice of the decision as expeditiously as possible, but not later than 72 hours after the receipt of the request.
- Require that issuers include a description of the external review process in the summary plan description, policy, certificate, membership booklet, outline of coverage, or other evidence of coverage it provides to claimants, substantially similar to what is set forth in section 17 of the NAIC Uniform Model Act.
- Require that IROs maintain written records and make them available upon request to the State, substantially similar to what is set forth in section 15 of the NAIC Uniform Model Act.
- Follow procedures for external review of adverse benefit determinations involving experimental or investigational treatment, substantially similar to what is set forth in section 10 of the NAIC Uniform Model Act.

The Departments invite comments on this list of minimum consumer protections and whether other elements of the NAIC Uniform Model Act should be included in the list.

The Department of Health and Human Services will determine whether a State external review process meets these requirements (and thus whether issuers (and, if applicable, plans) subject to the State external review process must comply with the State external review process rather than the Federal external review process). A transition period will be provided, however, during which existing State external review processes may be treated as satisfying these requirements.

Under PHS Act section 2719, if a State external review process does not provide the minimum consumer protections of the NAIC Uniform Model Act, health insur-

ance issuers in the State must implement the Federal external review process. The Departments' initial review of existing State external review processes indicates that not all State external review processes provide the minimum consumer protections of the NAIC Uniform Model Act. Under PHS Act section 2719(c), the Departments are provided with discretion to consider an external review process in place on the date of enactment of the Affordable Care Act to be in compliance with the external review requirement under section 2719(b) "as determined appropriate." In order to allow States time to amend their laws to meet or go beyond the minimum consumer protections of the NAIC Uniform Model Act set forth in these interim final regulations, the Departments are using their authority under PHS Act section 2719(c) to treat existing State external review processes as meeting the minimum standards during a transition period for plan years (in the individual market, policy years) beginning before July 1, 2011.

Thus, for plan or policy years beginning before July 1, 2011, a health insurance issuer subject to an existing State external review process must comply with that State external review process and not the Federal external review process. The applicable external review process for plan or policy years beginning on or after July 1, 2011 depends on the type of coverage and whether the State external review process has been determined by the Department of Health and Human Services to satisfy the minimum standards of the NAIC Uniform Model Act.

The applicable external review process for any particular claim is based on the external review process applicable to the plan or issuer at the time a final internal adverse benefit determination (or, in the case of simultaneous internal appeals and external review, the adverse benefit determination) is provided. For this purpose, the final internal adverse benefit determination includes a deemed final internal adverse benefit determination in which the internal claims and appeals process is exhausted because of the failure by the plan or issuer to comply with the requirements of the internal claims and appeals process. Thus, for an issuer with a calendar year plan year in a State in which the State external review process fails to meet the

minimum standards, external review of final internal adverse benefit determinations provided prior to the first day of the first calendar year on or after July 1, 2011 (that is, January 1, 2012) must comply with the State external review process, while external reviews of final internal adverse benefit determinations provided on or after January 1, 2012 must meet the alternative Federal external review requirements.

An additional provision of the NAIC Uniform Model Act not addressed in the interim final regulations is the required scope of an applicable State external review process. The NAIC Uniform Model Act applies to all issuers in a State. The Departments' initial review of existing State external review processes indicates that some States do not apply the State external review process to all issuers in the State. For example, some State external review processes only apply to HMOs and do not apply to other types of health coverage. The Departments believe that State external review processes are more effective, and thus more protective, where the external review process is market-wide and available to all claimants with insured coverage. As States with external review processes decide whether to enact legislation amending their laws to provide the consumer protections that would satisfy the requirements of these interim final regulations, the Departments encourage States to establish external review processes that are available for all insured health coverage. This is consistent with the Departments general approach of having States take a lead role in providing consumer protections, with Federal enforcement only as a fallback measure.

That said, these interim final regulations do not set a specific standard for availability of the State external review process that is considered to meet the minimum consumer protections of the NAIC Uniform Model Act. If it is determined that market-wide application of the State external review process is required, plans and issuers would be subject to the Federal external review process in States that do not apply the State external review process to all issuers in the State. Alternatively,

if it is determined that universal availability is not required, those plans and issuers that are not subject to the State external review process would be, as are self-insured plans, subject to the Federal external review process. The Departments seek comments whether the Federal external review process should apply to all plans and issuers in a State if the State external review process does not apply to all issuers in the State. After reviewing the comments, the Departments expect to issue future guidance addressing the issue.

d. Federal external review process

PHS Act section 2719(b)(2) requires the Departments to establish standards, "through guidance," governing an external review process that is similar to the State external appeals process that meets the standards in these regulations. These interim final regulations set forth the scope of claims eligible for review under the Federal external review process. Specifically, under the Federal external review process, the terms "adverse benefit determination" and "final internal adverse benefit determination" are defined the same as they are for purposes of internal claims and appeals (and, thus, include rescissions of coverage). However, an adverse benefit determination or final internal adverse benefit determination that relates to a participant's or beneficiary's failure to meet the requirements for eligibility under the terms of a group health plan (*i.e.*, worker classification and similar issues) is not within the scope of the Federal external review process.

These interim final regulations set forth the standards that would apply to claimants, plans, and issuers under this Federal external review process, and the substantive standards that would be applied under this process. They also reflect the statutory requirement that the process established through guidance from the Departments be similar to a State external review process that complies with the standards in these regulations. They also provide that the Federal external review process, like the State external review

process, will provide for expedited external review and additional consumer protections with respect to external review for claims involving experimental or investigational treatment. The Departments will address in sub-regulatory guidance how non-grandfathered self-insured group health plans that currently maintain an internal appeals process that otherwise meets the Federal external review standards may comply or be brought into compliance with the requirements of the new Federal external review process.

e. Culturally and linguistically appropriate

The statute and these interim final regulations require that notices of available internal claims and appeals and external review processes be provided in a culturally and linguistically appropriate manner. Plans and issuers are considered to provide relevant notices in a culturally and linguistically appropriate manner if notices are provided in a non-English language as described these interim final regulations.¹⁶ Under these interim final regulations, the requirement to provide notices in a non-English language is based on thresholds of the number of people who are literate in the same non-English language. In the group market, the threshold differs depending on the number of participants in the plan. For a plan that covers fewer than 100 participants at the beginning of a plan year, the threshold is 25 percent of all plan participants being literate only in the same non-English language. For a plan that covers 100 or more participants at the beginning of a plan year, the threshold is the lesser of 500 participants, or 10 percent of all plan participants, being literate only in the same non-English language. The thresholds are adapted from the Department of Labor's regulations regarding style and format for a summary plan description, at 29 CFR 2520.102-2(c). In the individual market, the threshold is 10 percent of the population residing in the county being literate only in the same non-English language.¹⁷ The Department of Health and

¹⁶ For internal claims involving urgent care (for which the claim is generally made by a health care provider), where paragraph (g) of the DOL claims procedure regulation permits an initial oral notice of determination must be made within 24 hours and follow-up in written or electronic notification within 3 days of the oral notification, it may not be reasonable, practicable, or appropriate to provide notice in a non-English language within 24 hours. In such situations, the requirement to provide notice in a culturally and linguistically appropriate manner is satisfied if the initial notice is provided in English and the follow-up notice is provided in the appropriate non-English language.

¹⁷ The county-by-county approach is generally adapted from the approach used under the Medicare Advantage program.

Human Services will publish guidance that issuers may consult to establish these county level estimates on its website at <http://www.hhs.gov/ociio/> by September 23, 2010. The Department of Health and Human Services welcomes comments on whether the threshold should remain 10 percent and whether it should continue to be applied on a county-by-county basis.

If an applicable threshold is met, notice must be provided upon request in the non-English language with respect to which the threshold is met. In addition, the plan or issuer must also include a statement in the English versions of all notices, prominently displayed in the non-English language, offering the provision of such notices in the non-English language. Once a request has been made by a claimant, the plan or issuer must provide all subsequent notices to a claimant in the non-English language. In addition, to the extent the plan or issuer maintains a customer assistance process (such as a telephone hotline) that answers questions or provides assistance with filing claims and appeals, the plan or issuer must provide such assistance in the non-English language.

f. Secretarial authority

The statute provides the Departments with the authority to deem an external review process of a group health plan or health insurance issuer, in operation as of March 23, 2010, to be in compliance with PHS Act section 2719. These interim final regulations provide the Departments may determine that the external review process of a plan or issuer, in operation as of March 23, 2010, is considered in compliance with a State external review process or the Federal external review process, as applicable.

g. Applicability date

The requirements to implement effective internal and external claims and appeals processes apply for plan years (in the individual market, policy years) beginning on or after September 23, 2010. The statute and these interim final regulations do not apply to grandfathered health plans. See 26 CFR 54.9815–1251T, 29 CFR 2590.715–1251, and 45 CFR 147.140 (75 FR 34538, June 17, 2010).

III. Interim Final Regulations and Request for Comments

Section 9833 of the Code, section 734 of ERISA, and section 2792 of the PHS Act authorize the Secretaries of the Treasury, Labor, and HHS (collectively, the Secretaries) to promulgate any interim final rules that they determine are appropriate to carry out the provisions of chapter 100 of the Code, part 7 of subtitle B of title I of ERISA, and part A of title XXVII of the PHS Act, which include PHS Act sections 2701 through 2728 and the incorporation of those sections into ERISA section 715 and Code section 9815.

In addition, under Section 553(b) of the Administrative Procedure Act (APA) (5 U.S.C. 551 *et seq.*) a general notice of proposed rulemaking is not required when an agency, for good cause, finds that notice and public comment thereon are impracticable, unnecessary, or contrary to the public interest. The provisions of the APA that ordinarily require a notice of proposed rulemaking do not apply here because of the specific authority granted by section 9833 of the Code, section 734 of ERISA, and section 2792 of the PHS Act. However, even if the APA were applicable, the Secretaries have determined that it would be impracticable and contrary to the public interest to delay putting the provisions in these interim final regulations in place until a full public notice and comment process was completed. As noted above, the internal claims and appeals and external review provisions of the Affordable Care Act are applicable for plan years (in the individual market, policy years) beginning on or after September 23, 2010, six months after date of enactment. Had the Departments published a notice of proposed rulemaking, provided for a 60-day comment period, and only then prepared final regulations, which would be subject to a 60-day delay in effective date, it is unlikely that it would have been possible to have final regulations in effect before late September, when these requirements could be in effect for some plans or policies. Moreover, the requirements in these interim final regulations require significant lead time in order to implement. These interim final regulations re-

quire plans and issuers to provide internal claims and appeals and external review processes and to notify participants, beneficiaries, and enrollees of their rights to such processes. Plans and issuers will presumably need to amend current internal claims and appeals procedures, adopt new external review processes, and notify participants, beneficiaries, and enrollees of these changes before they go into effect. Moreover, group health plans and health insurance issuers subject to these provisions will have to take these changes into account in establishing their premiums, and in making other changes to the designs of plan or policy benefits. In some cases, issuers will need time to secure approval for these changes in advance of the plan or policy year in question.

Accordingly, in order to allow plans and health insurance coverage to be designed and implemented on a timely basis, regulations must be published and available to the public well in advance of the effective date of the requirements of the Affordable Care Act. It is not possible to have a full notice and comment process and to publish final regulations in the brief time between enactment of the Affordable Care Act and the date regulations are needed.

The Secretaries further find that issuance of proposed regulations would not be sufficient because the provisions of the Affordable Care Act protect significant rights of plan participants and beneficiaries and individuals covered by individual health insurance policies and it is essential that participants, beneficiaries, insureds, plan sponsors, and issuers have certainty about their rights and responsibilities. Proposed regulations are not binding and cannot provide the necessary certainty. By contrast, the interim final regulations provide the public with an opportunity for comment, but without delaying the effective date of the regulations.

For the foregoing reasons, the Departments have determined that it is impracticable and contrary to the public interest to engage in full notice and comment rulemaking before putting these interim final regulations into effect, and that it is in the public interest to promulgate interim final regulations.

IV. Economic Impact and Paperwork Burden

A. Summary—Department of Labor and Department of Health and Human Services

As stated earlier in this preamble, these interim final regulations implement PHS Act section 2719, which sets forth rules with respect to internal claims and appeals and external appeals processes for group health plans and health insurance issuers that are not grandfathered health plans.¹⁸ This provision generally is effective for plan years (in the individual market, policy years) beginning on or after September 23, 2010, which is six months after the March 23, 2010 date of enactment of the Affordable Care Act.

The Departments have crafted these interim final regulations to secure the protections intended by Congress in the most economically efficient manner possible. In

accordance with OMB Circular A–4, the Departments have quantified the benefits and costs where possible and provided a qualitative discussion of some of the benefits and costs that may stem from these interim final regulations.

B. Executive Order 12866—Department of Labor and Department of Health and Human Services

Under Executive Order 12866 (58 FR 51735), “significant” regulatory actions are subject to review by the Office of Management and Budget (OMB). Section 3(f) of the Executive Order defines a “significant regulatory action” as an action that is likely to result in a rule (1) having an annual effect on the economy of \$100 million or more in any one year, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local or tribal govern-

ments or communities (also referred to as “economically significant”); (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President’s priorities, or the principles set forth in the Executive Order. OMB has determined that this rule is significant within the meaning of section 3(f)(1) of the Executive Order, because it is likely to have an effect on the economy of \$100 million in any one year. Accordingly, OMB has reviewed these rules pursuant to the Executive Order. The Departments provide an assessment of the potential costs and benefits of each regulatory provision below, summarized in table 1.

TABLE. 1—Accounting Table

Benefits				
Qualitative: A more uniform, rigorous, and consumer friendly system of claims and appeals processing will provide a broad range of direct and indirect benefits that will accrue to varying degrees to all of the affected parties. These interim final regulations could improve the extent to which employee benefit plans provide benefits consistent with the established terms of individual plans. While payment of these benefits will largely constitute transfers, the transfers will be welfare improving, because incorrectly denied benefits will be paid. Greater certainty and consistency in the handling of benefit claims and appeals and improved access to information about the manner in which claims and appeals are adjudicated should lead to efficiency gains in the system, both in terms of the allocation of spending across plans and enrollees as well as operational efficiencies among individual plans. This certainty and consistency can also be expected to benefit, to varying degrees, all parties within the system, particularly consumers, and to lead to broader social welfare gains.				
Costs	Estimate	Year Dollar	Discount Rate	Period Covered
Annualized Monetized (\$millions/year)	51.2	2010	7%	2011–2013
	51.6	2010	3%	2011–2013
Qualitative: The Departments have quantified the primary source of costs associated with these interim final regulations that will be incurred to (i) administer and conduct the internal and external review process, (ii) prepare and distribute required disclosures and notices, and (iii) bring plan and issuers’ internal and external claims and appeals procedures into compliance with the new requirements. The Departments also have quantified the start-up costs for issuers in the individual market to bring themselves into compliance.				

¹⁸ The Affordable Care Act adds Section 715 to the Employee Retirement Income Security Act (ERISA) and section 9815 to the Internal Revenue Code (the Code) to make the provisions of part A of title XXVII of the PHS Act applicable to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans, under ERISA and the Code as if those provisions of the PHS Act were included in ERISA and the Code.

Reversals				
Annualized Monetized (\$millions/year)	24.4	2010	7%	2011–2013
	24.7	2010	3%	2011–2013
Qualitative: The Departments estimated the dollar amount of claim denials reversed in the external review process. While this amount is a cost to plans, it represents a payment of benefits that should have previously been paid to participants, but was denied. Part of this amount is a transfer from plans and issuers to those now receiving payment for denied benefits. These transfers will improve equity, because incorrectly denied benefits will be paid. Part of the amount could also be a cost if the reversal leads to services and hence resources being utilized now that had been denied previously. The Departments are not able to distinguish between the two types, but believe that most reversals are associated with a transfer.				

1. Need for Regulatory Action

Before the enactment of the Affordable Care Act, health plan sponsors and issuers were not uniformly required to implement claims and appeals processes. For example, ERISA-covered group health plan sponsors were required to implement internal claims and appeal processes that complied with the DOL claims procedure regulation,¹⁹ while group health plans that were not covered by ERISA, such as plans sponsored by State and local governments were not. Health insurance issuers offering coverage in the individual insurance market were required to comply with various applicable State internal appeals laws but were not required to comply with the DOL claims procedure regulation.

With respect to external appeal processes, before the enactment of the Affordable Care Act, sponsors of fully-insured ERISA-covered group health plans, fully-insured State and local governmental plans, and fully-insured church plans were required to comply with State external review laws, while self-insured ERISA-covered group health plans were not subject to such laws due to ERISA preemption.²⁰ In the individual health insurance market, issuers in States with external review laws were required to comply with such laws. However, uniform external review standards did not apply, because State external review laws vary from State-to-State. Moreover, at least six States did not have external review laws when the Affordable Care Act was enacted; therefore, issuers in those States were not required to implement an external review process.

Under this regulatory system, inconsistent claims and appeals processes applied to plan sponsors and issuers and a patchwork of consumer protections were provided to participants, beneficiaries, and enrollees. The applicable processes and protections depended on several factors including whether (i) plans were subject to ERISA, (ii) benefits were self-funded or financed by the purchase of an insurance policy, (iii) issuers were subject to State internal claims and appeals laws, and (iv) issuers were subject to State external review laws, and if so, the scope of such laws (such as, whether the laws only apply to one segment of the health insurance market, *e.g.*, managed care or HMO coverage). These uneven protections created an appearance of unfairness, increased cost for issuers and plans operating in multiple States, and may have led to confusion among consumers about their rights.

Congress enacted new PHS Act section 2719 to ensure that plans and issuers implemented more uniform internal and external claims and appeals processes and to set a minimum standard of consumer protections that are available to participants, beneficiaries, and enrollees. These interim final regulations are necessary to provide rules that plan sponsors and issuers can use to implement effective internal and external claims and appeals processes that meet the requirements of new PHS Act section 2719.

2. PHS Act Section 2719 — Claims and Appeals Process (26 CFR 54.9815–2719T, 29 CFR 2590.715–2719, 45 CFR 147.136)

a. Summary

As discussed earlier in this preamble, section 1001 of the Affordable Care Act adds new PHS Act section 2719, which requires all non-grandfathered group health plans and health insurance issuers offering group or individual health coverage to implement uniform internal claims and appeals and external appeals processes. Under PHS Act section 2719 and these interim final regulations, all sponsors of non-grandfathered group health plans and health insurance issuers offering group or individual health insurance coverage must comply with all requirements of the DOL claims procedures regulation²¹ as well as the new standards that are established by the Secretary of Labor and the Secretary of Health and Human Services in paragraphs (b)(2) and (b)(3) of these interim final regulations.

On the external appeals side, all group health plans or health insurance issuers offering group or individual health insurance coverage that are not grandfathered must comply with an applicable State external review process that, at a minimum, includes the consumer protections set forth in the Uniform Health Carrier External Review Model Act promulgated by the National Association of Insurance Commissioners (the “NAIC Uniform Model Act”) and is binding on the plan or issuer. If the State has not established an external review process that meets the requirements

¹⁹ 29 CFR 2560.503–1.

²⁰ To the extent that the ERISA preemption provisions do not prevent a State external review process from applying to a self-insured plan (for example, for self-insured nonfederal governmental plans, self-insured church plans, and self-insured multiple employer welfare arrangements) the State could make its external review process applicable to them. The Departments are unaware of the number of these plans that are subject to State external review laws.

²¹ Please note that under these interim final regulations, the individual health insurance market is not required to comply with the requirements of the Department of Labor’s claims and appeals procedure regulation that apply to multiemployer plans.

of the NAIC Uniform Model Act or a plan is not subject to State insurance regulation, (including a State law that establishes an external review process) because it is a self-insured plan, the plan or issuer must comply with the requirements of a Federal external review process set forth in paragraph (d) of these interim final regulations.

b. Estimated Number of Affected Entities

For purposes of the new requirements in the Affordable Care Act that apply to group health plans and health insurance issuers in the group and individual markets, the Departments have defined a large group health plan as an employer plan with 100 or more workers and a small group plan as an employer plan with fewer than 100 workers. The Departments make the following estimates about plans and issuers affected by these interim final regulations: (1) there are approximately 72,000 large and 2.8 million small ERISA-covered group health plans with an estimated 97.0 million participants in large group plans and 40.9 million participants in small group plans;²² (2) there are 126,000 governmental plans with 36.1 million participants in large plans and 2.3 million participants in small plans;²³ and (3) there are 16.7 million individuals under age 65 covered by individual health insurance policies.²⁴

As described in the Departments' interim final regulations relating to status as a grandfathered health plan,²⁵ the Affordable Care Act preserves the ability of individuals to retain coverage under a group health plan or health insurance coverage in which the individual was enrolled on March 23, 2010 (a grandfathered health

plan). Group health plans and individual health insurance coverage that are grandfathered health plans do not have to meet the requirements of these interim final regulations. Therefore, only plans and issuers offering group and individual health insurance coverage that are not grandfathered health plans will be affected by these interim final regulations.

Plans can choose to make certain disqualifying changes and relinquish their grandfather status.²⁶ The Affordable Care Act provides plans with the ability to maintain grandfathered status in order to promote stability for consumers while allowing plans and sponsors to make reasonable adjustments to lower costs and encourage the efficient use of services. Based on an analysis of the changes plans have made over the past few years, the Departments expect that more plans will choose to make these changes over time and therefore the number of grandfathered health plans is expected to decrease. Correspondingly, the number of plans and policies affected by these interim final regulations is likely to increase over time. In addition, the number of individuals receiving the full benefits of the Affordable Care Act is likely to increase over time. The Departments estimate that 18 percent of large employer plans and 30 percent of small employer plans would relinquish grandfather status in 2011, increasing over time to 45 percent and 66 percent respectively by 2013, although there is substantial uncertainty surrounding these estimates.²⁷ The Departments also estimate that in 2011, roughly 31 million people will be enrolled in group health plans subject to PHS Act section 2719 and

these interim final regulations, growing to approximately 78 million in 2013.²⁸

In the individual market, one study estimated that 40 percent to 67 percent of individual policies terminate each year.²⁹ Because newly purchased individual policies are not grandfathered, the Departments expect that a large proportion of individual policies will not be grandfathered, covering up to and perhaps exceeding 10 million individuals.

Not all potentially affected individuals will be affected equally by these interim final regulations. As stated in the Need for Regulatory Action section above, sponsors of ERISA-covered group health plans were required to implement an internal appeals process that complied with the DOL claims procedure regulation before the Affordable Care Act's enactment, and the Departments also understand that many non-Federal governmental plans and church plans that are not subject to ERISA nonetheless implement internal claims and appeals processes that comply with the DOL claims procedure regulation.³⁰ Therefore, participants and beneficiaries covered by such plans only will be affected by the new internal claims and appeals standards that are provided by the Secretary of Labor in paragraph (b)(2)(ii) of these interim final regulations.

These interim final regulations will have the largest impact on individuals covered in the individual health insurance market, because as discussed earlier in this preamble, for the first time, these issuers will be required to comply with the DOL claims procedure regulation for internal claims and appeals as well as the additional standards added by the Secretary

²² All participant counts and the estimates of individual policies are from the U.S. Department of Labor, EBSA calculations using the March 2009 Current Population Survey Annual Social and Economic Supplement and the 2008 Medical Expenditure Panel Survey.

²³ Estimate is from the 2007 Census of Government.

²⁴ US Census Bureau, Current Population Survey, March 2009.

²⁵ 75 FR 34538 (June 17, 2010).

²⁶ See 75 FR 34538 (June 17, 2010).

²⁷ See 75 Fed. Reg. 34538 (June 17, 2010) for a detailed description of the derivation of the estimates for the percentages of grandfathered health plans. In brief, the Departments used data from the 2008 and 2009 Kaiser Family Foundations/Health Research and Educational Trust survey of employers to estimate the proportion of plans that made changes in cost-sharing requirements that would have caused them to relinquish grandfather status if those same changes were made in 2011, and then applied a set of assumptions about how employer behavior might change in response to the incentives created by the grandfather regulations to estimate the proportion of plans likely to relinquish grandfather status. The estimates of changes in 2012 and 2013 were calculated by using the 2011 calculations and assuming that an identical percentage of plan sponsors will relinquish grandfather status in each year.

²⁸ To estimate the number of individuals covered in grandfathered health plans, the Departments extended the analysis described in 75 Fed. Reg. 34538, and estimated a weighted average of the number of employees in grandfathered health plans in the large employer and small employer markets separately, weighting by the number of employees in each employer's plan. Estimates for the large employer and small employer markets were then combined, using the estimates supplied above that there are 133.1 million covered lives in the large group market, and 43.2 million in the small group market.

²⁹ Adele M. Kirk. *The Individual Insurance Market: A Building Block for Health Care Reform?* Health Care Financing Organization Research Synthesis. May 2008.

³⁰ This understanding is based on the Departments' conversations with industry experts. In addition, the Departments understand that ERISA-covered plans, State and local government plans, and non-ERISA covered church plans generally use the same insurance issuers and service providers who apply the ERISA claims and appeals requirements to all types of plans.

of the Department of Health and Human Services in paragraph (b)(3) of these interim final regulations that are in some cases more protective than the ERISA standard.³¹

On the external appeals side, before the enactment of the Affordable Care Act, issuers offering coverage in the group and individual health insurance market already were required to comply with State external review laws. At that time, all States except Alabama, Mississippi, Nebraska, North Dakota, South Dakota, and Wyoming had external review laws, and thirteen States had external review laws that apply only to certain market segments (for example, managed care or HMOs). Therefore, the extent to which enrollees covered by policies issued by these issuers will be affected by these interim final regulations depends on whether the applicable State external review law complies with the minimum consumer protections set forth in the NAIC Uniform Model Act, because if it does not, the policies will become subject to the Federal external review process that applies to self-insured plans that are not subject to State regulation³² and plans and policies in States that do not have external review laws that meet the minimum consumer protections set forth in the NAIC Uniform Model Act.

Individuals participating in ERISA-covered self-insured group health plans will be among those most affected by the external review requirements contained in these interim final regulations, because the preemption provisions of ERISA prevent a State's external review process from applying directly to an ERISA-covered self-insured plan.³³ These plans now will be required to comply with the Federal external review process set forth under paragraph (d) of these interim final regulations.

In summary, the number of affected individuals depends on several factors, including whether (i) a health plan retains its grandfather status, (ii) the plan is sub-

ject to ERISA, (iii) benefits provided under the plan are self-funded or financed by the purchase of an insurance policy, (iii) the applicable State has enacted an internal claims and appeals law, and (iv) the applicable State has enacted an external review law, and if so the scope of such law, and (v) the number of new plans and enrollees in such plans.

c. *Benefits*

In developing these interim final regulations, the Departments closely considered their potential economic effects, including both costs and benefits. Because of data limitations and a lack of effective measures, the Departments did not attempt to quantify expected benefits. Nonetheless, the Departments were able to identify with confidence several of the interim final regulation's major economic benefits.

These interim final regulations will help transform the current, highly variable health claims and appeals process into a more uniform and structured process. As stated in the Need for Regulatory Action above, before the enactment of the Affordable Care Act, inconsistent internal and external claims and appeals standards applied to plan sponsors and issuers, and a patchwork of consumer protections were provided to participants, beneficiaries, and enrollees that depended on several factors including whether (i) plans were subject to ERISA, (ii) benefits were self-funded or financed by the purchase of an insurance policy, (iii) issuers were subject to State internal claims and appeals laws, and (iv) issuers were subject to State external review laws, and if so, the scope of such laws (such as, whether the laws only apply to one segment of the health insurance market, *e.g.*, managed care or HMO coverage).

A more uniform, rigorous, and consumer friendly system of claims and appeals processing will provide a broad range of direct and indirect benefits that

will accrue to varying degrees to all of the affected parties. In general, the Departments expect that these interim final regulations will improve the extent to which employee benefit plans provide benefits consistent with the established terms of individual plans. This will cause some participants to receive benefits that, absent the fuller protections of the regulation, they might otherwise have been incorrectly denied. In other circumstances, expenditures by plans may be reduced as a fuller and fairer system of claims and appeals processing helps facilitate enrollee acceptance of cost management efforts. Greater certainty and consistency in the handling of benefit claims and appeals and improved access to information about the manner in which claims and appeals are adjudicated may lead to efficiency gains in the system, both in terms of the allocation of spending at a macro-economic level as well as operational efficiencies among individual plans. This certainty and consistency can also be expected to benefit, to varying degrees, all parties within the system and to lead to broader social welfare gains, particularly for consumers.

By making claims and appeals processes more uniform, these interim final regulations will increase efficiency in the operation of employee benefit plans and health care delivery as well as health insurance and labor markets. These interim final regulations are expected to increase efficiency by reducing complexity that arises when different market segments are subject to varying claims and appeals standards. Idiosyncratic requirements, time-frames, and procedures for claims processing impose substantial burdens on participants, their representatives, and service providers. By establishing a more uniform and complete set of minimum requirements and consumer protections, these interim final regulations will reduce the complexity of claims and appeals processing requirements, thereby increasing efficiency.

³¹ To address certain relevant differences in the group and individual markets, health insurance issuers offering individual health insurance coverage must comply with the following three additional requirements: (1) expand the scope of the claims and appeals process to cover initial eligibility determinations; (2) provide only one level of internal appeal (although the DOL claims procedure regulation permits group health plans to have a second level of internal appeals), which allows claimants to seek either an external appeal or judicial review immediately after an adverse determination is upheld in the first level of internal appeal; and (3) maintain records of all claims and notices associated with their internal claims and appeals processes and make such records available for examination upon request by claimants and Federal or State regulatory officials.

³² To the extent that the ERISA preemption provisions do not prevent a State external review process from applying to a self-insured plan (for example, for self-insured nonfederal governmental plans, self-insured church plans, and self-insured multiple employer welfare arrangements) the State could make its external review process applicable to such plans if it includes, at a minimum, the consumer protections in the NAIC Uniform Model Act.

³³ While it is possible that some ERISA-covered self-insured plans may have adopted external review procedures as a matter of good business practice, the Departments are uncertain regarding the level to which this has occurred.

The Departments expect that these interim final regulations also will improve the efficiency of health plans by enhancing their transparency and fostering participants' confidence in their fairness. When information about the terms and conditions under which benefits will be provided is unavailable to enrollees, they could discount the value of benefits to compensate for the perceived risk. The enhanced disclosure and notice requirements of these interim final regulations will help participants, beneficiaries, and enrollees better understand the reasons underlying adverse benefit determinations and their appeal rights.

The Departments believe that excessive delays and inappropriate denials of health benefits are relatively rare. Most claims are approved in a timely fashion. Many claim denials and delays are appropriate given the plan's terms and the circumstances at hand. Nonetheless, to the extent that delays and inappropriate denials occur, substantial harm can be suffered by participants, beneficiaries, and enrollees, which can also lead to an associated loss of confidence in the fairness and benefits of the system. A more timely and complete review process required under these interim final rules regulations should reduce the levels of delay and error in the system and improve health outcomes.

The voluntary nature of the employment-based health benefit system in conjunction with the open and dynamic character of labor markets make explicit as well as implicit negotiations on compensation a key determinant of the prevalence of employee benefits coverage. The prevalence of benefits is therefore largely dependent on the efficacy of this exchange. If workers perceive that there is the potential for inappropriate denial of benefits or handling of appeals, they will discount the value of such benefits to adjust for this risk. This discount drives a wedge in compensation negotiation, limiting its efficiency. With workers unwilling to bear the full cost of the benefit, fewer benefits will be provided. To the extent that workers perceive that these interim final regulations, supported by enforcement authority, reduces the risk of inappropriate denials of benefits, the differential between the employers' costs and workers' willingness to accept wage offsets is minimized.

Effective claims procedures also can improve health care, health plan quality, and insurance market efficiency by serving as a communication channel, providing feedback from participants, beneficiaries, and providers to plans about quality issues. Aggrieved claimants are especially likely to disenroll if they do not understand their appeal rights, or if they believe that their plans' claims and appeals procedures will not effectively resolve their difficulties. Unlike appeals, however, disenrollments fail to alert plans to the difficulties that prompted them. More uniform and effective appeals procedures can give participants and beneficiaries an alternative way to respond to difficulties with their plans. Plans in turn can use the information gleaned from the appeals process to improve services.

The Departments also expect that these interim final regulations' higher standard for more uniform internal and external claims appeals adjudication will enhance some insurers' and group health plans' abilities to effectively control costs by limiting access to inappropriate care. Providing a more formally sanctioned framework for internal and external review and consultation on difficult claims facilitates the adoption of cost containment programs by employers who, in the absence of a regulation providing some guidance, may have opted to pay questionable claims rather than risk alienating participants or being deemed to have breached a fiduciary duty.

In summary, the interim final regulations' more uniform standards for handling health benefit claims and appeals will reduce the incidence of excessive delays and inappropriate denials, averting serious, avoidable lapses in health care quality and resultant injuries and losses to participant, beneficiaries and enrollees. They also will enhance enrollees' level of confidence in and satisfaction with their health care benefits and improve plans' awareness of participant, beneficiary, and provider concerns, prompting plan responses that improve health care quality. Finally, by helping to ensure prompt and precise adherence to contract terms and by improving the flow of information between plans and enrollees, the interim final regulations will bolster the efficiency of labor, health care, and insurance markets. The Departments therefore conclude that the

economic benefits of these interim final regulations will justify their costs.

d. Costs and Transfers

The Departments have quantified the primary source of costs associated with these interim final regulations that will be incurred to (i) administer and conduct the internal and external review process, (ii) prepare and distribute required disclosures and notices, and (iii) bring plan and issuers' internal and external claims and appeals procedures into compliance with the new requirements. The Departments also have quantified the start-up costs for issuers in the individual market to bring themselves into compliance and the costs and the transfers associated with the reversal of denied claims during the external review process. These costs and the methodology used to estimate them are discussed below.

i. Internal Claims and Appeals

As discussed above, these interim final regulations require all group health plans and issuers offering coverage in the group and individual health insurance market to comply with the DOL claims procedure regulation. The ERISA-covered market, with an estimated 2.8 million plans and 138 million covered participants, already is required to comply with the DOL claims procedure regulation and is far larger than either the non-Federal governmental plan market, with an estimated 126,000 governmental plans and 30 million participants, or the individual market, with 16.7 million participants. As stated in the Estimated Number of Affected Entities section, the Departments understand that many non-Federal governmental plans comply with the DOL claims procedure regulation, because they use the same issuers and service providers as ERISA-covered plans, and these issuers and service providers implement the internal claims and appeals process for plans in both markets. Therefore, for purposes of this regulatory impact analysis, the Departments assume that 90 percent of the claims volume in the non-Federal governmental group health plan

market already complies with the DOL claims procedure regulation.³⁴

The Departments estimate that 170 issuers offer policies only in the individual market.³⁵ While the Departments believe that some issuers are subject to applicable state laws governing internal appeals processes, and have evidence that some issuers already comply with the DOL claims procedure regulation, some issuers will have to change their internal claims and appeals processes to comply with these interim final regulations.³⁶ The Departments estimate that issuers would incur a start-up cost of \$3.5 million in the first year to comply with these interim final regulations by revising processes, creating or revising forms, modifying systems, and training personnel. These costs are mitigated by the model notice of initial benefit determination the Departments will be issuing in subregulatory guidance. This notice will not require any data to be provided that cannot be automatically populated by plans and issuers.

ii. *Cost Required to Implement DOL Claims Procedure Regulation Requirements.* The Departments' estimates of the annual costs for plans and issuers to comply with the DOL claims procedure regulation are based on the methodology used for the Paperwork Reduction Act (PRA) hour and cost burden analysis of DOL claims procedure regulation.³⁷ The Department first estimated the number

of individuals covered by non-grandfathered plans using the March 2009 Current Population Survey Annual Social and Economic Supplement and the 2008 Medical Expenditure Panel Survey. Each covered individual was estimated to generate 10.2 claims on average per year,³⁸ 82 percent of which were filed electronically.³⁹ The Departments then assumed that 15 percent of these claims were denied.⁴⁰ The Departments assume that three percent of these claims were pre-service with the remaining being post-service claims.⁴¹ The number of post-service claims extended was based on the share of "clean" claims that took more than 30 days to complete processing.⁴² The share of denials expected to be appealed, 0.2 percent, was based on a RAND study.⁴³ The Departments expect half of these appeals to be reversed,⁴⁴ and those not reversed were divided between "medical claims" (28.9 percent) and "administrative claims" (71.1 percent).

The Departments attributed costs to notifying individuals of denied claims and processing appeals. Initial denials were assumed to only take a few minutes for a clerical worker to draft and send an adverse benefit determination notice based on the model notice that will be issued by the Departments that does not require any information to be included that cannot be auto-populated. Appealed denials deemed "medical" are assumed to require

a physician, with an estimated labor rate of \$154.07 to review and was expected to take 4 1/2 hours to decide and draft a response, regardless of outcome.⁴⁵ Appealed denials deemed "administrative" require a legal professional with an estimated labor rate of \$119.03, and a decision and response was expected to take two minutes for a reversal and two hours for a denial.⁴⁶ Mailing costs for the notice of adverse determination and notice of decision of internal appeal is estimated at 54 cents a notice for material, printing, and postage costs.

Because ERISA-covered plans already are required to comply with the DOL claims procedure regulation, the Departments did not attribute any cost to these plans to comply with the rule. As stated above, the Departments understand from consulting with industry experts that a substantial majority of State and local government plans also currently comply with the existing DOL claims procedure regulation; therefore, the Departments assumed that only ten percent of the estimated claims of individuals covered by these plans would constitute a new expense. All claims in non-grandfathered plans in the individual market were assumed to bear the full cost of compliance, because these policies are being required to comply with the DOL claims procedure regulation for the first time. Table 2 shows the estimated number of claims.

³⁴ The Departments are uncertain regarding the 90 percent compliance rate for State and local government plans. Therefore, to establish a range, the Departments estimated the cost assuming 75 percent State and local governmental plan compliance. Assuming 75 percent compliance, the cost of State and local plan internal review compliance would increase from \$2 million to \$5 million in 2011, \$3.6 million to \$9.1 million in 2012, and \$5 million to \$12.4 million in 2012.

³⁵ Source: Estimates are from NAIC 2007 financial statements data and the California Department of Managed Healthcare (2009) (<http://wpso.dnhc.ca.gov/hpsearch/viewall.aspx>)

³⁶ Discussions with the National Association of Insurance Commissioners suggest that three States require issuers in the individual market to follow the NAIC internal grievance appeals model. Eleven States have no set procedures in place, while the rest have varying requirements. Some issuers voluntarily follow the ERISA claims and appeals procedures.

³⁷ The OMB Control Number for the DOL procedure regulation is 1210-0053. OMB approved the three-year renewal of the Control Number through May 31, 2013, on May 21, 2010.

³⁸ Research at the time of the Claims Regulation as well as responses to the Claims RFI reported a wide range of claims per participant — between 5 and 18. The Department eventually settled on 10.2.

³⁹ AHIP, "Update: A Survey of Health Care Claims Receipt and Processing Times, 2009," January 2010.

⁴⁰ Health Insurance Association of America (HIAA, which later merged with AHIP) reported a denial rate of 14 percent in "Results from an HIAA Survey on Claims Payment Process," March 2003. These included duplicate claims as well as denied claims that were appeals. RAND reported an increased trend in claim denials in, "Inside the Black Box of Managed Care Decisions," Research Brief, 2004 from 3 percent to between 8 and 10 percent.

⁴¹ The assumption that 3 percent of claims are pre-service is based on comments the Department received in response to the proposed DOL claims procedure regulation in 2000.

⁴² AHIP, "Update: A Survey of Health Care Claims Receipt and Processing Times, 2009," January 2010.

⁴³ "Inside the Black Box of Managed Care Decisions," Research Brief, 2004

⁴⁴ The Department based this assumption on the number of appealed Medicare pre-authorization denials. They received comments for the proposed regulation arguing this estimate was either too high or too low and so the Department chose to retain the assumption.

⁴⁵ The Department in its initial claims regulation assumed that an expert consultation would cost \$500 which translated into roughly 5 hours of a physician's time. EBSA has revised this slightly downward based on the costs reported by IROs to review medical claims.

⁴⁶ The Departments' estimates of labor rates include wages, other benefits, and overhead based on the National Occupational Employment Survey (May 2008, Bureau of Labor Statistics) and the Employment Cost Index June 2009, Bureau of Labor Statistics).

TABLE. 2—Estimated Claims and Appeals in Non-grandfathered Coverage

	2011			2012			2013		
	Private Sector ESI	Government Sector ESI	Individual Market	Private Sector ESI	Government Sector ESI	Individual Market	Private Sector ESI	Government Sector ESI	Individual Market
Total Enrollees (millions)	138.0	39.0	15.1	138.0	39.0	15.1	138.0	39.0	15.1
Non-Grandfathered Enrollees	24.4	6.9	6.0	44.5	12.6	9.7	61.0	17.2	11.8
Total Claims (millions)	248.9	70.4	61.5	453.8	128.3	98.5	622.4	175.9	120.6
Pre-Service									
Claim Approved	6.3	1.8	1.6	11.6	3.3	2.5	15.9	4.5	3.1
Claim Denied	1.1	0.3	0.3	2.0	0.6	0.4	2.8	0.8	0.5
Post-Service									
Claims Approved	196.2	55.5	45.2	357.8	101.1	72.3	490.7	138.7	88.6
Claim Denied	36.2	10.2	9.0	66.0	18.7	14.3	90.6	25.6	17.6
Claim Extended	9.0	2.5	5.6	16.4	4.6	8.9	22.5	6.3	10.9
Total Internal Appeals (thousands)	85.4	24.1	52.8	155.7	44.0	84.5	213.6	60.4	103.5
Appeals Upheld	34.2	9.7	21.1	62.3	17.6	33.8	85.4	24.1	41.4
Appeals Denied	51.2	14.5	31.7	93.4	26.4	50.7	128.1	36.2	62.1
Medical subtotal	24.7	7.0	15.3	45.0	12.7	24.4	61.7	17.4	29.9
Appeals Upheld	9.9	2.8	6.1	18.0	5.1	9.8	24.7	7.0	12.0
Appeals Denied	14.8	4.2	9.2	27.0	7.6	14.6	37.0	10.5	17.9
Administrative subtotal	60.7	17.2	37.5	110.7	31.3	60.1	151.8	42.9	73.6
Appeals Upheld	24.3	6.9	15.0	44.3	12.5	24.0	60.7	17.2	29.4
Appeals Denied	36.4	10.3	22.5	66.4	18.8	36.0	91.1	25.8	44.1
Total New External Appeals (thousands)	2.0	0.6	0.2	3.7	1.1	0.3	5.0	1.5	0.4

As shown in Table 3 below, the Departments estimate that the cost of the internal process, including the costs of internal appeals and notice distribution, is \$1.5 million in 2011 and rises to \$3.8 million in 2013 as the number of non-grandfathered plans increases. The Departments estimate that the cost for the internal review process for the individual market is \$28.8 million in 2011 and rises to \$56.4 million in 2013.

iii. *Additional Requirements for Group Health Plans.* As discussed earlier in this preamble, paragraph (b)(2)(i) of these interim final regulations imposes additional requirements to the DOL claims procedure regulation that must be satisfied by group health plans and issuers offering group and individual coverage in the individual and group health insurance markets. The Departments believe that the additional re-

quirements have modest costs associated with them, because they merely clarify provisions of the DOL claims procedure regulation. These requirements and their associated costs are discussed below.

Definition of adverse determination. These interim final regulations expand the definition of adverse benefit determination to include rescissions of coverage. While new, the methodology used to estimate the burden for the internal appeals process already captures this burden as most rescissions are associated with a claim and therefore would already be accounted for. The requirement allows for appeal of rescinded coverage that does not have an associated claim. While the Departments lack data to estimate the number of rescissions that occur without an asso-

ciated claim for benefits, the Departments believe this number is small.

Expedited notification of benefit determination involving urgent care. The current DOL claims procedure regulation requires that a plan or issuer provide notification in the case of an urgent care claim as soon as possible taking into account the medical exigencies, but no later than 72 hours after receipt of the claim by the plan. These interim final regulations reduce the time limit to no later than 24 hours after the receipt of the claim by the plan or issuer. The Departments are not able to quantify the costs of this requirement. However, two factors could suggest this requirement does not impose substantial cost. First, the DOL claims procedure regulation requires urgent care notification to be made as soon as possible; therefore, it is likely

that some claims currently are handled in less than the 24 hours. In addition, the technological developments that have occurred since the 72 hour standard was issued in the 2000 DOL claims procedure regulation should facilitate faster notification at reduced costs. However, plans and issuers would incur additional cost for urgent care notices that take longer than the required 24 hours to produce. Speeding up the notification process for these determinations might necessitate incurring additional cost to add more employees or find other ways to shorten the timeframe. Additional costs may be associated with this requirement if a shorter timeframe results in claims being denied that would not have been under a 72 hour standard or claims being approved that would have been denied under a longer notification period.

Full and fair review. These interim final regulations require the plan or issuer to provide the claimant, free of charge, with any new or additional evidence relied upon or generated by the plan or issuer and the rationale used for a determination during the appeals process sufficiently in advance of the due date of the response to an adverse benefit determination. This requirement increases the administrative burden on plans and issuers to prepare and deliver the new and additional information to the claimant. The Departments are not aware of data suggesting how often plans rely on new or additional evidence during the appeals process or the volume of materials that are received.

For purposes of this regulatory impact analysis, the Departments assume, as an upper bound, that all appealed claims will involve a reliance on additional evidence. The Departments assume that this requirement will impose a cost of just under \$1 million in 2013, the year with the highest cost. The Departments estimated this cost by assuming that it will require medical office staff with a labor rate of \$26.85 five minutes⁴⁷ to collect and distribute the additional evidence considered, relied on, or generated during the appeals process. The Departments estimate that on average, material, printing and postage costs will be \$2.24 per mailing. The Departments further assume that 38 percent of all mail-

ings will be distributed electronically with no associated material, printing or postage costs.⁴⁸

Eliminating conflicts of interest. As discussed earlier in this preamble, these interim final regulations require plans and issuers to ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood or perceived likelihood that the individual will support or tend to support the denial of benefits.

This requirement could require plans or issuers to change policies that currently create a conflict of interest and to discontinue practices that create such conflicts. The Departments believe that many plans and issuers already have such requirements in place as a matter of good business practice, but do not have sufficient data to provide an estimate. However, the Departments believe that the cost associated with this requirement will be minimal.

Enhanced notice. These interim final regulations provide new standards regarding notice to enrollees. Specifically, the statute and these interim final regulations require a plan or issuer to provide notice to enrollees, in a culturally and linguistically appropriate manner (standards for which are described later in this preamble). Plans and issuers must comply with the requirements of paragraphs (g) and (j) of the DOL claims procedure regulation, which detail requirements regarding the issuance of a notice of adverse benefit determination. Moreover, for purposes of these interim final regulations, additional content requirements apply for these notices. A plan or issuer must ensure that any notice of adverse benefit determination or final adverse benefit determination includes information sufficient to identify the claim involved. This includes the date of service, the health care provider, and the claim amount (if applicable), as well as the

diagnosis code (such as an ICD-9 code, ICD-10 code, or DSM-IV code), the treatment code (such as a CPT code), and the corresponding meanings of these codes. A plan or issuer must also ensure that description of the reason or reasons for the denial includes a description of the standard that was used in denying the claim. In the case of a notice of final adverse benefit determination, this description must include a discussion of the decision. Additionally, the plan or issuer must provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal. Finally, the plan or issuer must disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793 to assist such enrollees with the internal claims and appeals and external review process. The Departments intend to issue model notices that could be used to satisfy all the notice requirements under these interim final regulations in the very near future that will mitigate the cost associated with providing them. These notices will be made available at <http://www.dol.gov/ebsa> and <http://www.hhs.gov/ociio/>. The cost of sending the notices is included in the costs of the internal and external review process. The Departments were unable to estimate the cost of providing the model notices in a linguistically and culturally appropriate manner. However the Departments believe the overall costs to be small as only a small number of plans are believed to be affected. The Departments request comments that could help in estimating these costs, particularly with respect to the individual insurance market.

Deemed exhaustion of internal process. These interim final regulations provide that, in the case of a plan or issuer that fails to strictly adhere to all the requirements of the internal claims and appeals process with respect to a claim, the claimant is deemed to have exhausted the internal claims and appeals process, regardless of whether the plan or issuer asserts that it substantially complied with these requirements or that the error was *de minimis*. Accordingly, under such deemed exhaus-

⁴⁷ EBSA estimates of labor rates include wages, other benefits, and overhead based on the National Occupational Employment Survey (May 2008, Bureau of Labor Statistics) and the Employment Cost Index June 2009, Bureau of Labor Statistics).

⁴⁸ This estimate is based on the methodology used to analyze the cost burden for the DOL claims procedure regulation (OMB Control Number 1210-0053).

tion, the claimant may initiate an external review and pursue any available remedies under applicable law, such as judicial review. The Departments are unable to quantify the costs that are associated with this requirement. While this provision possibly could result in an increased number of external appeals it could reduce overall costs if costly litigation is avoided.

Continued coverage. Finally, the statute and these interim final regulations require a plan and issuer to provide continued coverage pending the outcome of an internal appeal. For this purpose, the plan or issuer must comply with the requirements of paragraph (f)(2)(ii) of the DOL claims procedure regulation, which generally provide that a plan or issuer cannot reduce or terminate an ongoing course of treatment without providing advance notice and an opportunity for advance review. Moreover, as described more fully earlier in this preamble, the plan or issuer must also provide simultaneous external review in advance of a reduction or termination of an ongoing course of treatment.

This provision would not impose any additional cost on plans and issuers that comply with the DOL claims procedure regulation; however, costs would be incurred by issuers in the individual market. The Departments are unable to quantify the cost associated with this requirement, because they lack sufficient data on the number of simultaneous reviews that are conducted.⁴⁹

iv. Additional requirements for issuers in the individual insurance market

To address certain relevant differences in the group and individual markets, health insurance issuers offering individual health insurance coverage must comply with three additional requirements. First, these interim final regulations expand the scope of the group health coverage internal claims and appeals process to cover initial eligibility determinations. This

protection is important since eligibility determinations in the individual market are frequently based on the health status of the applicant, including preexisting conditions. The Departments do not have sufficient data to quantify the costs associated with this requirement.⁵⁰

Second, although the DOL claims procedure regulation permits group health plans to have a second level of internal appeals, these interim final regulations require health insurance issuers offering individual health insurance coverage to have only one level of internal appeals. This allows the claimant to seek either external review or judicial review immediately after an adverse determination is upheld in the first level of internal appeals. The Departments have factored this cost into their estimate of the cost for issuers offering coverage in the individual market to comply with requirement.

Finally, these interim final regulations require health insurance issuers offering individual health insurance coverage to maintain records of all claims and notices associated with their internal claims and appeals processes. An issuer must make such records available for examination upon request. Accordingly, a claimant or State or Federal agency official generally would be able to request and receive such documents free of charge. The Departments believe that minimal costs are associated with this requirement, because most issuers retain the required information in the normal course of their business operations.

v. External appeals

The analysis of the cost associated with implementing an external review process under these interim final regulations focuses on the cost incurred by the following three groups that were not required to implement an external review process before the enactment of the Affordable Care Act: plans and participants in ERISA-covered

self-insured plans; plans and participants in States with no external review laws, and plans and participants in States that have State laws only covering specific market segment (usually HMOs or managed care coverage).

The Departments estimate that there are about 76.9 million participants in self-insured ERISA-covered plans and approximately 13.8 million participants in self-insured State and local governmental plans. In the States which currently have no external review laws there are an estimated 4.2 million participants (2.5 million participants in ERISA-covered plans, 1.2 million participants in governmental plans and 0.6 million in individual with policies in the individual market). In the States that currently have limited external review laws, there are 15.6 million participants (8.4 million participants in ERISA-covered plans, 4.2 million participants in governmental plans and 3.0 million individuals with individual health insurance in the individual market). These estimates lead to a total of 110.5 million participants, however, only the 44.2 million participants in non-grandfathered plans will be newly covered by the external review requirement in 2011. As plans relinquish their grandfather status in subsequent years, more individuals will be covered.

The Departments assume that there are an estimated 1.3 external appeals for every 10,000 participants,⁵¹ and that there will be approximately 2,600 external appeals in 2011. As required by these interim final regulations or applicable State law, plans or issuers are required to pay for most of the cost of the external review while claimants may be charged a modest filing fee. A recent report finds that the average cost of a review was approximately \$605.⁵² While the actual cost per review will vary by state and also type of review (standard or expedited), an older study covering many States suggests this is a reasonable estimate.⁵³ These estimates

⁴⁹ The Departments do not have a basis to estimate this, because the Departments do not know how often this denial takes place or how often they are appealed. The costs should be minimal, because the decisions will be made quickly, and the period of coverage will be brief. The Departments expect the cost to be small relative to the cost of reversals, which the Departments have estimated.

⁵⁰ However, the Departments believe this number to be small. Approximately 10 to 15 percent of applicants are declined coverage in the individual market, while the Departments do not know how many of those denied coverage will appeal, using appeal rates for internal and external appeals would result in only a few thousand appeals. See "Fundamentals of Underwriting in the nongroup Health Insurance Market," pages 10–12, April 13, 2005.

⁵¹ AHIP Center for Policy and Research, "An Update on State External Review Programs, 2006," July 2008.

⁵² North Carolina Department of Insurance "Healthcare Review Program: Annual Report," 2008.

⁵³ Pollitz, Karen, Jeff Crowley, Kevin Lucia, and Eliza Bangit "Assessing State External Review Programs and the Effects of Pending Federal Patient's Rights Legislation." Kaiser Family Foundation (2002) page 27.

lead to an estimated cost of the external review of \$1.6 million (2,600 reviews * \$605) in 2011. Using a similar method and adjusting for the number of non-grandfathered plans in subsequent years, the Departments estimate that the total cost for external review is \$2.9 million in 2012 and \$3.9 million in 2013.

On average, about 40 percent of denials are reversed on external appeal.⁵⁴ An estimate of the dollar amount per claim reversed is \$12,400.⁵⁵ This leads to \$13.4 million in additional claims being reversed by the external review process in 2011, which increases to \$33.1 million in 2013. While this amount is a cost to plans, it represents a payment of benefits that should have previously been paid to participants, but was denied. Part of this amount is

a transfer from plans and issuers to those now receiving payment for denied benefits. Part of the amount could also be a cost if the reversal leads to services and hence resources being utilized now that had been denied previously. The Departments are not able to distinguish between the two types but believe that most reversals are associated with a transfer.

These interim final regulations also require claimants to receive a notice informing them of the outcome of the appeal. The independent review organization that conducts the external review is required to prepare the notice; therefore, the cost of preparing and delivering this notice is included in the fee paid them by the insurer to conduct the review.

3. Summary

These interim final rules extend the protections of the DOL claims procedure regulation to non-Federal governmental plans, and the market for individual coverage. Additional protections are added that cover these two markets and also the market for ERISA covered plans. These interim final regulations also extend the requirement to provide an independent external review. The Departments estimate that the total costs for these interim final regulations is \$50.4 million in 2011, \$78.8 million in 2012, and \$101.1 million in 2013. The estimates are summarized in table 3, below.

TABLE. 3—*Monetized Impacts of Interim Final Regulations (in millions)*

	2011	2012	2013
ERISA Market	\$1.4	\$2.5	\$3.5
External Review	\$1.2	\$2.2	\$3.1
Internal Review*	\$0.0	\$0.0	\$0.0
Fair and Full Review	\$0.2	\$0.3	\$0.4
State & Local Government Market	\$2.4	\$4.3	\$6.0
External Review	\$0.4	\$0.6	\$0.9
Internal Review**	\$2.0	\$3.6	\$5.0
Fair and Full Review	\$0.05	\$0.1	\$0.1
Individual Market	\$32.5	\$46.4	\$56.8
External Review	\$0.1	\$0.2	\$0.2
Internal Review	\$28.8	\$46.0	\$56.4
Fair and Full Review	\$0.1	\$0.2	\$0.2
Recordkeeping	\$0.1	\$0.1	\$0.1
Start-up Costs	\$3.5	\$0.0	\$0.0
Total Costs	\$36.2	\$53.2	\$66.2
Amount of Reversals***	\$14.2	\$25.6	\$34.9
ERISA Plans	\$10.3	\$18.7	\$25.7
State & Local Government Plans	\$3.0	\$5.4	\$7.4
Individual Market	\$0.9	\$1.5	\$1.9

*Assumes that ERISA plans already comply with ERISA claims and appeals regulations.

**Assumes that 90 percent of State and Local Government plans already comply with the ERISA claims and appeals regulation.

***This amount includes both transfers and costs with identical offsetting benefits.

C. Regulatory Flexibility Act—Department of Labor and Department of Health and Human Services

The Regulatory Flexibility Act (5 U.S.C. 601 et seq.) (RFA) imposes certain requirements with respect to Federal rules that are subject to the notice and comment requirements of section 553(b) of the APA (5 U.S.C. 551 et seq.)

and that are likely to have a significant economic impact on a substantial number of small entities. Section 9833 of the Code, section 734 of ERISA, and section 2792 of the PHS Act authorize the Secretaries to promulgate any interim final rules that

⁵⁴ AHIP Center for Policy and Research, "An Update on State External Review Programs, 2006," July 2008.

⁵⁵ North Carolina Department of Insurance "Healthcare Review Program: Annual Report," 2008.

they determine are appropriate to carry out the provisions of chapter 100 of the Code, part 7 of subtitle B or title I of ERISA, and part A of title XXVII of the PHS Act, which include PHS Act sections 2701 through 2728 and the incorporation of those sections into ERISA section 715 and Code section 9815.

Moreover, under Section 553(b) of the APA, a general notice of proposed rulemaking is not required when an agency, for good cause, finds that notice and public comment thereon are impracticable, unnecessary, or contrary to the public interest. These interim final regulations are exempt from APA, because the Departments made a good cause finding that a general notice of proposed rulemaking is not necessary earlier in this preamble. Therefore, the RFA does not apply and the Departments are not required to either certify that the rule would not have a significant economic impact on a substantial number of small entities or conduct a regulatory flexibility analysis.

Nevertheless, the Departments carefully considered the likely impact of the rule on small entities in connection with their assessment under Executive Order 12866. Consistent with the policy of the RFA, the Departments encourage the public to submit comments that suggest alternative rules that accomplish the stated purpose of the Affordable Care Act and minimize the impact on small entities.

D. Special Analyses-Department of the Treasury

Notwithstanding the determinations of the Department of Labor and Department of Health and Human Services, for purposes of the Department of the Treasury, it has been determined that this Treasury decision is not a significant regulatory action for purposes of Executive Order 12866. Therefore, a regulatory assessment is not required. It has also been determined that section 553(b) of the APA (5 U.S.C. chapter 5) does not apply to these interim final regulations. For the applicability of the RFA, refer to the Special Analyses section in the preamble to the cross-referencing notice of proposed rulemaking published elsewhere in this issue of the Bulletin. Pursuant to section 7805(f) of the Code, these temporary regulations have been submitted to the Chief Counsel for Advocacy

of the Small Business Administration for comment on their impact on small businesses.

E. Paperwork Reduction Act

1. Department of Labor and Department of the Treasury

As discussed above in the Department of Labor and Department of the Treasury PRA section, these interim final regulations require group health plans and health insurance issuers offering group or individual health insurance coverage to comply with the DOL claims procedure regulation with updated standards. They also require such plans and issuers to implement an external review process.

Currently, the Departments are soliciting 60 days of public comments concerning these disclosures. The Departments have submitted a copy of these interim final regulations to OMB in accordance with 44 U.S.C. 3507(d) for review of the information collections. The Departments and OMB are particularly interested in comments that:

- Evaluate whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;
- Evaluate the accuracy of the agency's estimate of the burden of the collection of information, including the validity of the methodology and assumptions used;
- Enhance the quality, utility, and clarity of the information to be collected; and
- Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, for example, by permitting electronic submission of responses.

Comments should be sent to the Office of Information and Regulatory Affairs, Attention: Desk Officer for the Employee Benefits Security Administration either by fax to (202) 395-7285 or by email to oir_submission@omb.eop.gov. A copy of the ICR may be obtained by contacting the PRA addressee: G. Christopher

Cosby, Office of Policy and Research, U.S. Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue, NW, Room N-5718, Washington, DC 20210. Telephone: (202) 693-8410; Fax: (202) 219-4745. These are not toll-free numbers. E-mail: ebbsa.opr@dol.gov. ICRs submitted to OMB also are available at [reginfo.gov](http://www.reginfo.gov) (<http://www.reginfo.gov/public/do/PRA-Main>).

a. Department of Labor and Department of the Treasury: Affordable Care Act Internal Claims and Appeals and External Review Disclosures for Non-Grandfathered Plans

As discussed earlier in this preamble, under PHS Act section 2719 and these interim final regulations, all sponsors of non-grandfathered group health plans and health insurance issuers offering group health insurance coverage must comply with all requirements of the DOL claims procedure regulation (29 CFR 2560.503-1) as well as the new standards in paragraph (b)(2)(ii) of these interim final regulations.

Before the enactment of the Affordable Care Act, ERISA-covered group health plans already were required to comply with the requirements of the DOL claims procedure regulation. The DOL claims procedure regulation requires, among other things, plans to provide a claimant who is denied a claim with a written or electronic notice that contains the specific reasons for denial, a reference to the relevant plan provisions on which the denial is based, a description of any additional information necessary to perfect the claim, and a description of steps to be taken if the participant or beneficiary wishes to appeal the denial. The regulation also requires that any adverse decision upon review be in writing (including electronic means) and include specific reasons for the decision, as well as references to relevant plan provisions. The Departments are not soliciting comments concerning an information collection request (ICR) pertaining to the requirement for ERISA-covered group health plans to meet the disclosure requirements of DOL's claims procedure regulation, because the costs and burdens associated with complying with these provisions already are accounted for un-

der the Department of Labor's Employee Benefit Plan Claims Procedure Under ERISA regulation (OMB Control Number 1210-0053).

Additional hour and cost burden is associated with paragraph (b)(2)(ii)(C) of these interim final regulations, which requires non-grandfathered ERISA-covered group health plans to provide the claimant, free of charge, with any new or additional evidence considered relied upon, or generated by the plan or issuer in connection with the claim.⁵⁶ This requirement increases the administrative burden on plans and issuers to prepare and deliver the additional information to the claimant.

Additional hour and cost burden also is associated with the requirement in paragraphs (c) and (d) of the regulations which set forth the external review requirements. The requirement for group health plans to implement an external review process will impose an hour and cost burden on plans that were not required to implement such a process before the enactment of the Affordable Care Act, such as self-insured plans, plans in states with no external review laws, and plans in states with limited scope external review laws (such as laws that only impact specific market segments like HMOs).

The Departments estimate that approximately 93 percent of large benefit and all small benefit plans administer claims using a third-party provider, or roughly 5 percent of covered individuals. In-house administration burdens are accounted for as hours, while purchased services are accounted for as dollar costs. Based on the foregoing, total burden hours are estimated at 300 hours in 2011, 500 hours in 2012, and 700 hours in 2013. Equivalent costs are \$11,000, \$19,000, and \$26,000 respectively.

As stated in the preceding paragraph, the bulk of claims will be processed by third-party service providers. Total cost is estimated by multiplying the number of responses by the amount of time required to prepare the documents and then multiplying this by the appropriate hourly cost of

either clerical workers (\$26.14) or doctors (\$154.07),⁵⁷ and then adding the cost of copying and mailing responses (\$0.54 each for those not sent electronically). Based on the foregoing, the Departments estimate that the total estimated cost burden for those plans that use service providers, including the cost of mailing all responses (including mailing costs for those prepared in-house listed in Table 2), is \$243,000 in 2011, \$443,000 in 2012, and \$607,000 in 2013.

Type of Review: New collection.

Agencies: Employee Benefits Security Administration, Department of Labor; Internal Revenue Service, U.S. Department of the Treasury,

Title: Affordable Care Act Internal Claims and Appeals and External Review Disclosures for Non-Grandfathered Plans
OMB Number: 1210-0144;
1545-2182.

Affected Public: Business or other for-profit; not-for-profit institutions.

Total Respondents: 607,000.

Total Responses: 62,000.

Frequency of Response: Occasionally.

Estimated Total Annual Burden Hours: 150 hours (Employee Benefits Security Administration); 150 hours (Internal Revenue Service).

Estimated Total Annual Burden Cost: \$121,500 (Employee Benefits Security Administration); \$121,500 (Internal Revenue Service).

2. Department of Health and Human Services

As discussed above in the Department of Labor and Department of the Treasury PRA section, these interim final regulations require group health plans and health insurance issuers offering group or individual health insurance coverage to comply with the DOL claims procedure regulation with updated standards. They also require such plans and issuers to implement an external review process.

a. ICR Regarding Affordable Care Act Internal Claims and Appeals

and External Review Disclosures for Non-grandfathered Plans

As discussed earlier in the preamble, paragraph (b)(2) and (b)(3) of these interim final regulations require all group health plan sponsors and health insurance issuers offering coverage in the group and individual health insurance markets to comply with the requirements of DOL's claims procedure regulation for their internal claims and appeals processes. Plan sponsors and issuers offering coverage in the group market also are required to satisfy the additional standards that are imposed on group health plans and issuers in paragraph (b)(2)(ii) of these interim final regulations, while issuers offering coverage in the individual health insurance market are required to satisfy the additional standards set forth in paragraph (b)(3)(ii) of these interim final regulations.

On the external review side, for purposes of this PRA analysis, the Department estimates the hour and cost burden for plans that were not previously subject to any external review requirements (self-insured plans, plans in states with no external review programs, and non-managed care plans in states that require external review only for managed care plans) to implement an external review process.

Based on the foregoing, the Department estimates that state and local governmental plans and issuers offering coverage in the individual market will incur a total hour burden hours of 566,000 hours in 2011, 989,000 hours in 2012, and 1.2 million hours in 2013 to comply with equivalent costs of \$28.1 million in 2011, \$57.1 million in 2012, and \$70.1 million in 2013. The total estimated cost burden for those plans that use service providers, including the cost of mailing all responses is estimated to be \$20.7 million in 2011, \$37.4 million in 2012, and \$51.1 million in 2013.

The hour and cost burden is summarized below:

Type of Review: New collection.

Agency: Department of Health and Human Services.

⁵⁶ Such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give the claimant a reasonable opportunity to respond prior to that date. Additionally, before the plan or issuer can issue an adverse benefit determination on review based on a new or additional rationale, the claimant must be provided, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give the claimant a reasonable opportunity to respond prior to that date.

⁵⁷ EBSA estimates of labor rates include wages, other benefits, and overhead based on the National Occupational Employment Survey (May 2008, Bureau of Labor Statistics) and the Employment Cost Index June 2009, Bureau of Labor Statistics).

Title: Affordable Care Act Internal Claims and Appeals and External Review Disclosures

OMB Number: 0938–1098.

Affected Public: Business; State, Local, or Tribal Governments.

Respondents: 27,829.

Responses: 132,035,000.

Frequency of Response: Occasionally.

Estimated Total Annual Burden Hours: 566,000 hours.

Estimated Total Annual Burden Cost: \$20,700,000.

b. ICR Regarding Affordable Care Act Recordkeeping Requirement for Non-grandfathered Plans

As discussed earlier in this preamble, a health insurance issuer offering individual

health insurance coverage must generally comply with all the requirements for the internal claims and appeals process that apply to group health coverage.⁵⁸ In addition to these standards, paragraph (b)(3)(ii)(H) of 45 CFR 147.136 requires health insurance issuers offering individual health insurance coverage to maintain records of all claims and notices associated with their internal claims and appeals processes. The records must be maintained for at least six years, which is the same requirement for group health plans under the ERISA recordkeeping requirements. An issuer must make such records available for examination upon request. Accordingly, a claimant or State or Federal agency official generally would be able to request and receive such documents free of charge.

The Department assumes that most of these records will be kept in the ordinary course of the issuers' business. Therefore, the Department estimates that the recordkeeping burden imposed by this ICR will require five minutes of a legal professional's time (with a rate of \$119.03/hour) to determine the relevant documents that must be retained and ten minutes of clerical staff time (with a labor rate of \$26.14/hour) to organize and file the required documents to ensure that they are accessible to claimants and Federal and State governmental agency officials. As shown in Table 4, below, overall, the Department estimates that there to be a total annual hour burden of 1,800 hours with an equivalent cost of \$105,000.

TABLE 4.—Total Hour Burden and Equivalent Cost

	Number (A)	Hours (B)	Hourly Labor Cost (C)	Hour Burden A*B	Equivalent Cost A*B*C
Record Keeping (attorney): individual	7,350	0.08	\$119	613	\$72,906
Record Keeping(clerical): Individual	7,350	0.17	\$26	1,225	\$32,022
Total				1,838	\$104,927

Because this burden is borne solely by the insurers offering coverage in the individual health insurance market, and these issuers are assumed to process all claims in-house, there is no annual cost burden associated with this collection of information.

These paperwork burden estimates are summarized as follows:

Type of Review: New collection.

Agency: Department of Health and Human Services.

Title: Affordable Care Act Recordkeeping Requirements.

OMB Number: 0938–1098.

Affected Public: For Profit Business.

Respondents: 490.

Responses: 7,350.

Frequency of Response: Occasionally.

Estimated Total Annual Burden Hours: 1800 hours.

Estimated Total Annual Burden Cost: \$0.

If you comment on any of these information collection requirements, please do either of the following:

1. Submit your comments electronically as specified in the ADDRESSES section of this proposed rule; or

2. Submit your comments to the Office of Information and Regulatory Affairs, Office of Management and Budget,

Attention: CMS Desk Officer,
OCIO–9994–IFC

Fax: (202) 395 6974; or

Email: OIRA_submission@omb.eop.gov

F. Congressional Review Act

These interim final regulations are subject to the Congressional Review Act

provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 *et seq.*) and have been transmitted to Congress and the Comptroller General for review.

G. Unfunded Mandates Reform Act

The Unfunded Mandates Reform Act of 1995 (Public Law 104–4) requires agencies to prepare several analytic statements before proposing any rules that may result in annual expenditures of \$100 million (as adjusted for inflation) by State, local and tribal governments or the private sector. These interim final regulations are not subject to the Unfunded Mandates Reform Act because they are being issued as interim final regulations. However, consistent with the policy embodied in the Unfunded Mandates Reform Act, the regu-

⁵⁸ The special rules in the DOL claims procedure regulation applicable only to multiemployer plans, as described earlier in this preamble, do not apply to health insurance issuers in the individual market.

lation has been designed to be the least burdensome alternative for State, local and tribal governments, and the private sector, while achieving the objectives of the Affordable Care Act.

H. Federalism Statement—Department of Labor and Department of Health and Human Services

Executive Order 13132 outlines fundamental principles of federalism, and requires the adherence to specific criteria by Federal agencies in the process of their formulation and implementation of policies that have “substantial direct effects” on the States, the relationship between the national government and States, or on the distribution of power and responsibilities among the various levels of government. Federal agencies promulgating regulations that have federalism implications must consult with State and local officials, and describe the extent of their consultation and the nature of the concerns of State and local officials in the preamble to the regulation.

In the Departments’ view, these interim final regulations have federalism implications, because they have direct effects on the States, the relationship between the national government and States, or on the distribution of power and responsibilities among various levels of government. However, in the Departments’ view, the federalism implications of these interim final regulations are substantially mitigated because, with respect to health insurance issuers, the Departments expect that the majority of States will enact laws or take other appropriate action to implement an internal and external appeals process that will meet or exceed federal standards.

In general, through section 514, ERISA supersedes State laws to the extent that they relate to any covered employee benefit plan, and preserves State laws that regulate insurance, banking, or securities. While ERISA prohibits States from regulating a plan as an insurance or investment company or bank, the preemption provisions of section 731 of ERISA and section 2724 of the PHS Act (implemented in 29 CFR 2590.731(a) and 45 CFR 146.143(a)) apply so that the HIPAA requirements (including those of the Affordable Care Act) are not to be “construed to supersede any

provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement” of a Federal standard. The conference report accompanying HIPAA indicates that this is intended to be the “narrowest” preemption of State laws. (See House Conf. Rep. No. 104–736, at 205, reprinted in 1996 U.S. Code Cong. & Admin. News 2018.) States may continue to apply State law requirements except to the extent that such requirements prevent the application of the Affordable Care Act requirements that are the subject of this rulemaking. State insurance laws that are more stringent than the Federal requirements are unlikely to “prevent the application of” the Affordable Care Act, and be preempted. Accordingly, States have significant latitude to impose requirements on health insurance issuers that are more restrictive than the Federal law. Furthermore, the Departments have opined that, in the instance of a group health plan providing coverage through group health insurance, the issuer will be required to follow the external review procedures established in State law (assuming the State external review procedure meets the minimum standards set out in these interim final rules).

In compliance with the requirement of Executive Order 13132 that agencies examine closely any policies that may have federalism implications or limit the policy making discretion of the States, the Departments have engaged in efforts to consult with and work cooperatively with affected State and local officials, including attending conferences of the National Association of Insurance Commissioners, meeting with NAIC staff counsel on issues arising from these interim final regulations and consulting with State insurance officials on an individual basis. It is expected that the Departments will act in a similar fashion in enforcing the Affordable Care Act requirements, including the provisions of section 2719 of the PHS Act. Throughout the process of developing these interim final regulations, to the extent feasible within the specific preemption provisions of HIPAA as it applies to

the Affordable Care Act, the Departments have attempted to balance the States’ interests in regulating health insurance issuers, and Congress’ intent to provide uniform minimum protections to consumers in every State. By doing so, it is the Departments’ view that they have complied with the requirements of Executive Order 13132.

V. Statutory Authority

The Department of the Treasury temporary regulations are adopted pursuant to the authority contained in sections 7805 and 9833 of the Code.

The Department of Labor interim final regulations are adopted pursuant to the authority contained in 29 U.S.C. 1027, 1059, 1135, 1161–1168, 1169, 1181–1183, 1181 note, 1185, 1185a, 1185b, 1191, 1191a, 1191b, and 1191c; sec. 101(g), Pub. L. 104–191, 110 Stat. 1936; sec. 401(b), Pub. L. 105–200, 112 Stat. 645 (42 U.S.C. 651 note); sec. 512(d), Pub. L. 110–343, 122 Stat. 3881; sec. 1001, 1201, and 1562(e), Pub. L. 111–148, 124 Stat. 119, as amended by Pub. L. 111–152, 124 Stat. 1029; Secretary of Labor’s Order 6–2009, 74 FR 21524 (May 7, 2009).

The Department of Health and Human Services interim final regulations are adopted pursuant to the authority contained in sections 2701 through 2763, 2791, and 2792 of the PHS Act (42 USC 300gg through 300gg–63, 300gg–91, and 300gg–92), as amended.

Steven T. Miller,
*Deputy Commissioner for
Services and Enforcement,
Internal Revenue Service.*

Approved July 19, 2010.

Michael F. Mundaca,
*Assistant Secretary of
the Treasury (Tax Policy).*

Signed this 16th day of July, 2010.

Phyllis C. Borzi,
*Assistant Secretary
Employee Benefits
Security Administration
Department of Labor.*

Dated: July 19, 2010.

Jay Angoff,
Director,
Office of Consumer Information
and Insurance Oversight.

Dated: July 19, 2010.

Kathleen Sebelius,
Secretary,
Department of Health
and Human Services.

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Chapter 1

Accordingly, 26 CFR Parts 54 and 602 are amended as follows:

PART 54—PENSION EXCISE TAXES

Paragraph 1. The authority citation for part 54 is amended by adding an entry for §54.9815–2719T in numerical order to read in part as follows:

Authority: 26 U.S.C. 7805 * * *

Section 54.9815–2719T also issued under 26 U.S.C. 9833.

Par. 2. Section 54.9815–2719T is added to read as follows:

§54.9815–2719T Internal claims and appeals and external review processes (temporary).

(a) *Scope and definitions*—(1) *Scope*. This section sets forth requirements with respect to internal claims and appeals and external review processes for group health plans and health insurance issuers that are not grandfathered health plans under §54.9815–1251T. Paragraph (b) of this section provides requirements for internal claims and appeals processes. Paragraph (c) of this section sets forth rules governing the applicability of State external review processes. Paragraph (d) of this section sets forth a Federal external review process for plans and issuers not subject to an applicable State external review process. Paragraph (e) of this section prescribes requirements for ensuring that notices required to be provided under this section are provided in a culturally and linguistically appropriate manner. Paragraph (f) of this section describes the authority of the Secretary to deem certain external

review processes in existence on March 23, 2010 as in compliance with paragraph (c) or (d) of this section. Paragraph (g) of this section sets forth the applicability date for this section.

(2) *Definitions*. For purposes of this section, the following definitions apply —

(i) *Adverse benefit determination*. An adverse benefit determination means an adverse benefit determination as defined in 29 CFR 2560.503–1, as well as any rescission of coverage, as described in §54.9815–2712T(a)(2) (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time).

(ii) *Appeal (or internal appeal)*. An appeal or internal appeal means review by a plan or issuer of an adverse benefit determination, as required in paragraph (b) of this section.

(iii) *Claimant*. Claimant means an individual who makes a claim under this section. For purposes of this section, references to claimant include a claimant's authorized representative.

(iv) *External review*. External review means a review of an adverse benefit determination (including a final internal adverse benefit determination) conducted pursuant to an applicable State external review process described in paragraph (c) of this section or the Federal external review process of paragraph (d) of this section.

(v) *Final internal adverse benefit determination*. A final internal adverse benefit determination means an adverse benefit determination that has been upheld by a plan or issuer at the completion of the internal appeals process applicable under paragraph (b) of this section (or an adverse benefit determination with respect to which the internal appeals process has been exhausted under the deemed exhaustion rules of paragraph (b)(2)(ii)(F) of this section).

(vi) *Final external review decision*. A final external review decision, as used in paragraph (d) of this section, means a determination by an independent review organization at the conclusion of an external review.

(vii) *Independent review organization (or IRO)*. An independent review organization (or IRO) means an entity that conducts independent external reviews of adverse benefit determinations and final internal adverse benefit determinations pursuant to paragraph (c) or (d) of this section.

(viii) *NAIC Uniform Model Act*. The NAIC Uniform Model Act means the Uniform Health Carrier External Review Model Act promulgated by the National Association of Insurance Commissioners in place on July 23, 2010.

(b) *Internal claims and appeals process*—(1) *In general*. A group health plan and a health insurance issuer offering group health insurance coverage must implement an effective internal claims and appeals process, as described in this paragraph (b).

(2) *Requirements for group health plans and group health insurance issuers*. A group health plan and a health insurance issuer offering group health insurance coverage must comply with all the requirements of this paragraph (b)(2). In the case of health insurance coverage offered in connection with a group health plan, if either the plan or the issuer complies with the internal claims and appeals process of this paragraph (b)(2), then the obligation to comply with this paragraph (b)(2) is satisfied for both the plan and the issuer with respect to the health insurance coverage.

(i) *Minimum internal claims and appeals standards*. A group health plan and a health insurance issuer offering group health insurance coverage must comply with all the requirements applicable to group health plans under 29 CFR 2560.503–1, except to the extent those requirements are modified by paragraph (b)(2)(ii) of this section. Accordingly, under this paragraph (b), with respect to health insurance coverage offered in connection with a group health plan, the group health insurance issuer is subject to the requirements in 29 CFR 2560.503–1 to the same extent as the group health plan.

(ii) *Additional standards*. In addition to the requirements in paragraph (b)(2)(i) of this section, the internal claims and appeals processes of a group health plan and a health insurance issuer offering group health insurance coverage must meet the requirements of this paragraph (b)(2)(ii).

(A) *Clarification of meaning of adverse benefit determination*. For purposes of this paragraph (b)(2), an “adverse benefit determination” includes an adverse benefit determination as defined in paragraph (a)(2)(i) of this section. Accordingly, in complying with 29 CFR 2560.503–1, as well as the other provisions of this paragraph (b)(2), a plan or issuer must treat

a rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at that time) as an adverse benefit determination. (Rescissions of coverage are subject to the requirements of §54.9815-2712T.)

(B) *Expedited notification of benefit determinations involving urgent care.* Notwithstanding the rule of 29 CFR 2560.503-1(f)(2)(i) that provides for notification in the case of urgent care claims not later than 72 hours after the receipt of the claim, for purposes of this paragraph (b)(2), a plan and issuer must notify a claimant of a benefit determination (whether adverse or not) with respect to a claim involving urgent care as soon as possible, taking into account the medical exigencies, but not later than 24 hours after the receipt of the claim by the plan or issuer, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan or health insurance coverage. The requirements of 29 CFR 2560.503-1(f)(2)(i) other than the rule for notification within 72 hours continue to apply to the plan and issuer. For purposes of this paragraph (b)(2)(ii)(B), a claim involving urgent care has the meaning given in 29 CFR 2560.503-1(m)(1).

(C) *Full and fair review.* A plan and issuer must allow a claimant to review the claim file and to present evidence and testimony as part of the internal claims and appeals process. Specifically, in addition to complying with the requirements of 29 CFR 2560.503-1(h)(2) —

(1) The plan or issuer must provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the plan or issuer (or at the direction of the plan or issuer) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided under 29 CFR 2560.503-1(i) to give the claimant a reasonable opportunity to respond prior to that date; and

(2) Before the plan or issuer can issue a final internal adverse benefit determination based on a new or additional rationale, the claimant must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on

which the notice of final internal adverse benefit determination is required to be provided under 29 CFR 2560.503-1(i) to give the claimant a reasonable opportunity to respond prior to that date.

(D) *Avoiding conflicts of interest.* In addition to the requirements of 29 CFR 2560.503-1(b) and (h) regarding full and fair review, the plan and issuer must ensure that

all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support the denial of benefits.

(E) *Notice.* A plan and issuer must provide notice to individuals, in a culturally and linguistically appropriate manner (as described in paragraph (e) of this section) that complies with the requirements of 29 CFR 2560.503-1(g) and (j). The plan and issuer must also comply with the additional requirements of this paragraph (b)(2)(ii)(E).

(1) The plan and issuer must ensure that any notice of adverse benefit determination or final internal adverse benefit determination includes information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).

(2) The plan and issuer must ensure that the reason or reasons for the adverse benefit determination or final internal adverse benefit determination includes the denial code and its corresponding meaning, as well as a description of the plan's or issuer's standard, if any, that was used in denying the claim. In the case of a notice of final internal adverse benefit determination, this description must include a discussion of the decision.

(3) The plan and issuer must provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal.

(4) The plan and issuer must disclose the availability of, and contact information

for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793 to assist individuals with the internal claims and appeals and external review processes.

(F) *Deemed exhaustion of internal claims and appeals processes.* In the case of a plan or issuer that fails to strictly adhere to all the requirements of this paragraph (b)(2) with respect to a claim, the claimant is deemed to have exhausted the internal claims and appeals process of this paragraph (b), regardless of whether the plan or issuer asserts that it substantially complied with the requirements of this paragraph (b)(2) or that any error it committed was *de minimis*. Accordingly the claimant may initiate an external review under paragraph (c) or (d) of this section, as applicable. The claimant is also entitled to pursue any available remedies under section 502(a) of ERISA or under State law, as applicable, on the basis that the plan or issuer has failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim. If a claimant chooses to pursue remedies under section 502(a) of ERISA under such circumstances, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

(iii) *Requirement to provide continued coverage pending the outcome of an appeal.* A plan and issuer subject to the requirements of this paragraph (b)(2) are required to provide continued coverage pending the outcome of an appeal. For this purpose, the plan and issuer must comply with the requirements of 29 CFR 2560.503-1(f)(2)(ii), which generally provides that benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review.

(c) *State standards for external review—(1) In general.* (i) If a State external review process that applies to and is binding on a health insurance issuer offering group health insurance coverage includes at a minimum the consumer protections in the NAIC Uniform Model Act, then the issuer must comply with the applicable State external review process and is not required to comply with the Federal external review process of paragraph (d) of this section. In such a case, to the extent that benefits under a group health plan are

provided through health insurance coverage, the group health plan is not required to comply with either this paragraph (c) or the Federal external review process of paragraph (d) of this section.

(ii) To the extent that a group health plan provides benefits other than through health insurance coverage (that is, the plan is self-insured) and is subject to a State external review process that applies to and is binding on the plan (for example, is not preempted by ERISA) and the State external review process includes at a minimum the consumer protections in the NAIC Uniform Model Act, then the plan must comply with the applicable State external review process and is not required to comply with the Federal external review process of paragraph (d) of this section.

(iii) If a plan or issuer is not required under paragraph (c)(1)(i) or (c)(1)(ii) of this section to comply with the requirements of this paragraph (c), then the plan or issuer must comply with the Federal external review process of paragraph (d) of this section, except to the extent, in the case of a plan, the plan is not required under paragraph (c)(1)(i) of this section to comply with paragraph (d) of this section.

(2) *Minimum standards for State external review processes.* An applicable State external review process must meet all the minimum consumer protections in this paragraph (c)(2). The Department of Health and Human Services will determine whether State external review processes meet these requirements.

(i) The State process must provide for the external review of adverse benefit determinations (including final internal adverse benefit determinations) by issuers (or, if applicable, plans) that are based on the issuer's (or plan's) requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

(ii) The State process must require issuers (or, if applicable, plans) to provide effective written notice to claimants of their rights in connection with an external review for an adverse benefit determination.

(iii) To the extent the State process requires exhaustion of an internal claims and appeals process, exhaustion must be unnecessary where the issuer (or, if applicable, the plan) has waived the requirement, the issuer (or the plan) is consid-

ered to have exhausted the internal claims and appeals process under applicable law (including by failing to comply with any of the requirements for the internal appeal process, as outlined in paragraph (b)(2) of this section), or the claimant has applied for expedited external review at the same time as applying for an expedited internal appeal.

(iv) The State process provides that the issuer (or, if applicable, the plan) against which a request for external review is filed must pay the cost of the IRO for conducting the external review. Notwithstanding this requirement, the State external review process may require a nominal filing fee from the claimant requesting an external review. For this purpose, to be considered nominal, a filing fee must not exceed \$25, it must be refunded to the claimant if the adverse benefit determination (or final internal adverse benefit determination) is reversed through external review, it must be waived if payment of the fee would impose an undue financial hardship, and the annual limit on filing fees for any claimant within a single plan year must not exceed \$75.

(v) The State process may not impose a restriction on the minimum dollar amount of a claim for it to be eligible for external review. Thus, the process may not impose, for example, a \$500 minimum claims threshold.

(vi) The State process must allow at least four months after the receipt of a notice of an adverse benefit determination or final internal adverse benefit determination for a request for an external review to be filed.

(vii) The State process must provide that IROs will be assigned on a random basis or another method of assignment that assures the independence and impartiality of the assignment process (such as rotational assignment) by a State or independent entity, and in no event selected by the issuer, plan, or the individual.

(viii) The State process must provide for maintenance of a list of approved IROs qualified to conduct the external review based on the nature of the health care service that is the subject of the review. The State process must provide for approval only of IROs that are accredited by a nationally recognized private accrediting organization.

(ix) The State process must provide that any approved IRO has no conflicts of interest that will influence its independence. Thus, the IRO may not own or control, or be owned or controlled by a health insurance issuer, a group health plan, the sponsor of a group health plan, a trade association of plans or issuers, or a trade association of health care providers. The State process must further provide that the IRO and the clinical reviewer assigned to conduct an external review may not have a material professional, familial, or financial conflict of interest with the issuer or plan that is the subject of the external review; the claimant (and any related parties to the claimant) whose treatment is the subject of the external review; any officer, director, or management employee of the issuer; the plan administrator, plan fiduciaries, or plan employees; the health care provider, the health care provider's group, or practice association recommending the treatment that is subject to the external review; the facility at which the recommended treatment would be provided; or the developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended.

(x) The State process allows the claimant at least five business days to submit to the IRO in writing additional information that the IRO must consider when conducting the external review and it requires that the claimant is notified of the right to do so. The process must also require that any additional information submitted by the claimant to the IRO must be forwarded to the issuer (or, if applicable, the plan) within one business day of receipt by the IRO.

(xi) The State process must provide that the decision is binding on the issuer (or, if applicable, the plan), as well as the claimant except to the extent that other remedies are available under State or Federal law.

(xii) The State process must require, for standard external review, that the IRO provide written notice to the claimant and the issuer (or, if applicable, the plan) of its decision to uphold or reverse the adverse benefit determination (or final internal adverse benefit determination) within no more than 45 days after the receipt of the request for external review by the IRO.

(xiii) The State process must provide for an expedited external review if the ad-

verse benefit determination (or final internal adverse benefit determination) concerns an admission, availability of care, continued stay, or health care service for which the claimant received emergency services, but has not been discharged from a facility; or involves a medical condition for which the standard external review time frame would seriously jeopardize the life or health of the claimant or jeopardize the claimant's ability to regain maximum function. As expeditiously as possible but within no more than 72 hours after the receipt of the request for expedited external review by the IRO, the IRO must make its decision to uphold or reverse the adverse benefit determination (or final internal adverse benefit determination) and notify the claimant and the issuer (or, if applicable, the plan) of the determination. If the notice is not in writing, the IRO must provide written confirmation of the decision within 48 hours after the date of the notice of the decision.

(xiv) The State process must require that issuers (or, if applicable, plans) include a description of the external review process in or attached to the summary plan description, policy, certificate, membership booklet, outline of coverage, or other evidence of coverage it provides to participants, beneficiaries, or enrollees, substantially similar to what is set forth in section 17 of the NAIC Uniform Model Act.

(xv) The State process must require that IROs maintain written records and make them available upon request to the State, substantially similar to what is set forth in section 15 of the NAIC Uniform Model Act.

(xvi) The State process follows procedures for external review of adverse benefit determinations (or final internal adverse benefit determinations) involving experimental or investigational treatment, substantially similar to what is set forth in section 10 of the NAIC Uniform Model Act.

(3) *Transition period for existing external review processes*—(i) For plan years beginning before July 1, 2011, an applicable State external review process applicable to a health insurance issuer or group health plan is considered to meet the requirements of this paragraph (c). Accordingly, for plan years beginning before July 1, 2011, an applicable State external review process will be considered binding on the issuer or plan (in lieu of the re-

quirements of the Federal external review process). If there is no applicable State external review process, the issuer or plan is required to comply with the requirements of the Federal external review process in paragraph (d) of this section.

(ii) For final internal adverse benefit determinations (or, in the case of simultaneous internal appeal and external review, adverse benefit determinations) provided after the first day of the first plan year beginning on or after July 1, 2011, the Federal external review process will apply unless the Department of Health and Human Services determines that a State law meets all the minimum standards of paragraph (c)(2) of this section as of the first day of the plan year.

(d) *Federal external review process*. A plan or issuer not subject to an applicable State external review process under paragraph (c) of this section must provide an effective Federal external review process in accordance with this paragraph (d) (except to the extent, in the case of a plan, the plan is described in paragraph (c)(1)(i) of this section as not having to comply with this paragraph (d)). In the case of health insurance coverage offered in connection with a group health plan, if either the plan or the issuer complies with the Federal external review process of this paragraph (d), then the obligation to comply with this paragraph (d) is satisfied for both the plan and the issuer with respect to the health insurance coverage.

(1) *Scope*. The Federal external review process established pursuant to this paragraph (d) applies to any adverse benefit determination or final internal adverse benefit determination as defined in paragraphs (a)(2)(i) and (a)(2)(v) of this section, except that a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a participant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan is not eligible for the external review process under this paragraph (d).

(2) *External review process standards*. The Federal external review process established pursuant to this paragraph (d) will be similar to the process set forth in the NAIC Uniform Model Act and will meet standards issued by the Secretary. These standards will comply with all of the

requirements described in this paragraph (d)(2).

(i) These standards will describe how a claimant initiates an external review, procedures for preliminary reviews to determine whether a claim is eligible for external review, minimum qualifications for IROs, a process for approving IROs eligible to be assigned to conduct external reviews, a process for random assignment of external reviews to approved IROs, standards for IRO decision-making, and rules for providing notice of a final external review decision.

(ii) These standards will provide an expedited external review process for —

(A) An adverse benefit determination, if the adverse benefit determination involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal under paragraph (b) of this section would seriously jeopardize the life or health of the claimant, or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal under paragraph (b) of this section; or

(B) A final internal adverse benefit determination, if the claimant has a medical condition where the timeframe for completion of a standard external review pursuant to paragraph (d)(3) of this section would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care service for which the claimant received emergency services, but has not been discharged from a facility.

(iii) With respect to claims involving experimental or investigational treatments, these standards will also provide additional consumer protections to ensure that adequate clinical and scientific experience and protocols are taken into account as part of the external review process.

(iv) These standards will provide that an external review decision is binding on the plan or issuer, as well as the claimant, except to the extent other remedies are available under State or Federal law.

(v) These standards may establish external review reporting requirements for IROs.

(vi) These standards will establish additional notice requirements for plans and issuers regarding disclosures to participants and beneficiaries describing the Federal external review procedures (including the right to file a request for an external review of an adverse benefit determination or a final internal adverse benefit determination in the summary plan description, policy, certificate, membership booklet, outline of coverage, or other evidence of coverage it provides to participants or beneficiaries).

(vii) These standards will require plans and issuers to provide information relevant to the processing of the external review, including, but not limited to, the information considered and relied on in making the adverse benefit determination or final internal adverse benefit determination.

(e) *Form and manner of notice.* (1) For purposes of this section, a group health plan and health insurance issuer offering group health insurance coverage are considered to provide relevant notices in a culturally and linguistically appropriate manner—

(i) For a plan that covers fewer than 100 participants at the beginning of a plan year, if the plan and issuer provide notices upon request in a non-English language in which 25 percent or more of all plan participants are literate only in the same non-English language; or

(ii) For a plan that covers 100 or more participants at the beginning of a plan year, if the plan and issuer provide notices upon request in a non-English language in which the lesser of 500 or more participants, or 10 percent or more of all plan participants, are literate only in the same non-English language.

(2) If an applicable threshold described in paragraph (e)(1) of this section is met, the plan and issuer must also—

(i) Include a statement in the English versions of all notices, prominently displayed in the non-English language, offering the provision of such notices in the non-English language;

(ii) Once a request has been made by a claimant, provide all subsequent notices to the claimant in the non-English language; and

(iii) To the extent the plan or issuer maintains a customer assistance process (such as a telephone hotline) that answers questions or provides assistance with filing claims and appeals, the plan or issuer must provide such assistance in the non-English language.

(f) *Secretarial authority.* The Secretary may determine that the external review process of a group health plan or health insurance issuer, in operation as of March 23, 2010, is considered in compliance with the applicable process established under para-

graph (c) or (d) of this section if it substantially meets the requirements of paragraph (c) or (d) of this section, as applicable.

(g) *Applicability/effective date.* The provisions of this section apply for plan years beginning on or after September 23, 2010. See §54.9815–1251T for determining the application of this section to grandfathered health plans (providing that these rules regarding internal claims and appeals and external review processes do not apply to grandfathered health plans).

(h) *Expiration date.* The applicability of this section expires on July 22, 2013 or on such earlier date as may be provided in final regulations or other action published in the **Federal Register**.

PART 602—OMB CONTROL NUMBERS UNDER THE PAPERWORK REDUCTION ACT

Par. 3. The authority citation for part 602 continues to read in part as follows:

Authority: 26 U.S.C. 7805.

Par. 4. Section 602.101(b) is amended by adding the following entry in numerical order to the table to read as follows:

§602.101 *OMB Control numbers.*

* * * * *
(b) * * *

CFR part or section where identified and described	Current OMB control No.
* * * * *	
54.9815–2719T	1545–2182
* * * * *	

(Filed by the Office of the Federal Register on July 22, 2010, 8:45 a.m., and published in the issue of the Federal Register for July 23, 2010, 75 F.R. 43329)

Part III. Administrative, Procedural, and Miscellaneous

Information Reporting Requirements Relating to Transfers of Securities

Notice 2010-67

PURPOSE

This notice provides transitional relief from the information reporting requirements in section 6045A of the Internal Revenue Code (“Code”) that apply beginning in 2011 to transfers of securities by brokers and other custodians. The notice provides that, solely for transfers of stock in 2011 described in the notice, the Internal Revenue Service will not assert penalties for failure to furnish a transfer statement under section 6045A and that the transferred stock may be treated as a noncovered security upon its subsequent sale or transfer.

BACKGROUND

Section 403 of the Energy Improvement and Extension Act of 2008, Div. B of Pub. L. No. 110-343, 122 Stat. 3765, enacted on October 3, 2008, added sections 6045(g), 6045A, and 6045B to the Code. Section 6045(g) provides that, in the case of a covered security, every broker required to report the gross proceeds from the sale of the security under section 6045(a) must also report the customer’s adjusted basis in the security and whether any gain or loss with respect to the security is long-term or short-term. The reporting is generally done on Form 1099-B, “*Proceeds from Broker and Barter Exchange Transactions*.” A covered security includes all stock acquired beginning in 2011 except stock in a regulated investment company for which the average basis method is available and stock acquired in

connection with a dividend reinvestment plan, both of which are covered securities if acquired beginning in 2012. A noncovered security is any security that is not a covered security.

To enable brokers to meet the requirements of section 6045(g) for securities transferred between accounts, section 6045A provides that, beginning in 2011, a broker and any other person specified in Treasury Regulations that transfers custody of a covered security to a receiving broker must furnish to the receiving broker a written statement that allows the receiving broker to satisfy the basis reporting requirements of section 6045(g). Except as provided by the Secretary, the statement must be furnished to the receiving broker within fifteen days after the date of the transfer. A covered security remains a covered security if transferred, but only if the receiving broker receives a transfer statement for the transfer.

To enable brokers to meet the requirements of section 6045(g) after an issuer of stock takes an organizational action such as a stock split, merger, or acquisition that affects basis, section 6045B provides that, beginning in 2011, an issuer must report to the Service and to each stockholder or nominee a description of any such action and the quantitative effect of that action on basis. This requirement does not apply until 2012 to regulated investment companies.

On December 17, 2009, the Treasury Department and the Service published a notice of proposed rulemaking and notice of public hearing (REG-101896-09, 2010-5 I.R.B. 347 [74 FR 67010]), on the information reporting requirements under sections 6045(g), 6045A, and 6045B. Many commenters on the proposed regulations stated that brokers and other custodians may have insufficient time to

make programming changes necessary to comply in 2011 with final regulations. Commenters requested relief in 2011 from the transfer statement requirement under section 6045A in order to allow industry to focus initially on building the core systems for reporting the sale of covered securities under section 6045(g) beginning in 2011. However, commenters stated that existing systems could accommodate reporting for any transfer of stock that is incidental to the stock’s purchase or sale using a cash-on-delivery account or multiple broker arrangement. See Treas. Reg. §1.6045-1(c)(3)(iii)-(iv).

TRANSITIONAL RELIEF FOR CERTAIN 2011 TRANSFERS

Section 6722 imposes a penalty on any transferor that fails to timely furnish a correct transfer statement under section 6045A to the receiving broker. In order to promote industry readiness to comply with the reporting requirements for the sale of covered securities under section 6045(g) beginning in 2011, the Service will not assert penalties under section 6722 for a failure to furnish a transfer statement under section 6045A for any transfer of stock in 2011 that is not incidental to the stock’s purchase or sale as described in Treas. Reg. §1.6045A-1(a)(1)(ii). Further, a receiving broker may treat this stock as a noncovered security.

DRAFTING INFORMATION

The principal author of this notice is Stephen Schaeffer of the Office of Associate Chief Counsel (Procedure & Administration). For further information regarding this notice, please contact Stephen Schaeffer at (202) 622-4910 (not a toll-free call).

Use this revenue procedure to prepare Tax Year 2010 and prior year information returns for submission to Internal Revenue Service (IRS) electronically using the Filing Information Returns Electronically (FIRE) System.

Rev. Proc. 2010–38

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Part A. General

Sec. 1. Purpose

.01 Section 6050M of the Internal Revenue Code, which was added by section 1522 of the Tax Reform Act of 1986 (Public Law 99–514) and amended by section 1015(f) of the Technical and Miscellaneous Revenue Act of 1988 (Public Law 100–647), requires Federal Executive Agencies to file an information return with the Internal Revenue Service (IRS) reporting the name, address and Taxpayer Identification Number (TIN) of each person and/or corporation with whom the agency enters into a contract, together with any other information required by Treasury regulations. Such reporting is required when the contract amount equals or exceeds \$25,000.00 including any amendments to the original contract.

.02 The purpose of this revenue procedure is to provide the specifications for filing Form 8596, Information Return for Federal Contracts, and Form 8596-A, Quarterly Transmittal of Information Returns for Federal Contracts, with IRS electronically through the Filing Information Returns Electronically (FIRE) System.

.03 This revenue procedure applies to Federal Executive Agencies, United States Postal Service and the Postal Rate Commission with respect to reporting their contracts and contract amendments where the net value of the contract exceeds \$25,000.00 Federal Executive Agencies generally must report contracts in excess of \$25,000.00 to the Federal Procurement Data Center (FPDC) and therefore are permitted to make an election to have the FPDC file with the Internal Revenue Service on their behalf. If the election is made by the Federal Executive Agency, it must be made by the head of the Agency (or his or her delegate). The agency must not file directly with IRS. See Part A, Section 5. Please read this Revenue Procedure carefully.

.04 This Revenue Procedure supersedes Rev. Proc. 2008–49, reprinted as Publication 1516 (Rev. 2010–38), Specifications for Filing Forms 8596, Information Returns for Federal Contracts, Electronically. Use this Revenue Procedure for filing Forms 8596 electronically for the quarter beginning January 2011.

Sec. 2. Nature of Changes

In this publication, all pertinent changes for Tax Year 2010 are emphasized by the use of *italics*. Portions of text that require special attention are in boldface text. Filers are always encouraged to read the publication in its entirety.

.01 Change in contact name from IRS/ECC-MTB to IRS/IRB (Information Returns Branch), Information Reporting Program to Information Returns Branch and added Mail Stop 4360 to mailing address.

.02 Payer “A” Record, expanded Type of Return field from a one position to a two position field. Previously the field position was 27, now it is field positions 26–27.

.03 Technical security standards added to Part B, Sec. 6.06 for the FIRE System.

Sec. 3. Where to File and How to Contact the IRS, Information Returns Branch

.01 All information returns filed electronically are processed at IRS/IRB. Files containing information returns and requests for IRS electronic filing information should be sent to the following address:

*Internal Revenue Service
Information Returns Branch
230 Murall Drive, Mail Stop 4360
Kearneysville, WV 25430*

.02 Telephone inquiries for the Information Reporting Program Customer Service Section may be made between 8:30 a.m. and 4:30 p.m. Eastern time, Monday through Friday.

.03 The telephone numbers for electronic submission inquiries are:

Information Reporting Program Customer Service Section

TOLL-FREE 1-866-455-7438 or outside the U.S. 1-304-263-8700

304-579-4827 — TDD
(Telecommunication Device for the Deaf)

Toll-free — 877-477-0572 — Fax Machine
Outside the U.S. use 304-579-4105

Electronic Filing — FIRE system
<http://fire.irs.gov>

TO OBTAIN FORMS:
1-800-TAX-FORM (1-800-829-3676)

www.irs.gov — IRS website access to forms

Sec. 4. Form 4419, Application for Filing Information Returns Electronically (FIRE)

.01 Transmitters are required to submit Form 4419, Application for Filing Information Returns Electronically, to request authorization to file information returns with IRS/IRB. A single Form 4419 should be filed no matter how many types of returns the transmitter will be submitting electronically. For example, if a transmitter plans to file Forms 8596, one Form 4419 should be submitted. If, at a later date, another type of form (Forms 1097, 1098, 1099, 3921, 3922, 5498 and W-2G) is to be filed, the transmitter does not need to submit a new Form 4419.

Note: EXCEPTIONS — An additional Form 4419 is required for filing each of the following types of returns: Form 1042-S, Foreign Person's U.S. Source Income Subject to Withholding, Form 8027, Employer's Annual Information Return of Tip Income and Allocated Tips and Forms 8955-SSA, Annual Registration Statement Identifying Separated Participants with Deferred Vested Benefits. See the back of Form 4419 for detailed instructions.

.02 Electronically filed returns may not be submitted to IRS/IRB until the application has been approved. Please read the instructions on the back of Form 4419 carefully. Forms may be obtained by calling **1-800-TAX-FORM (1-800-829-3676)**. The form is also available on the IRS website at www.irs.gov. This form may be photocopied.

.03 Upon approval, a five-character alpha/numeric Transmitter Control Code (TCC) will be assigned and included in an approval letter. The TCC **must** be coded in the Transmitter "T" Record. IRS/IRB uses the TCC to identify payers/transmitters and to track their files through the processing system.

.04 Form 4419 may be submitted anytime during the year; however, it **must** be submitted to IRS/IRB at least 30 days before the due date of the return(s) for current year processing. This will allow IRS/IRB the minimum amount of time necessary to process and respond to applications.

.05 Once a transmitter is approved to file electronically, it is not necessary to reapply **unless**:

- (a) The payer has discontinued filing electronically for two consecutive years. The payer's TCC may have been reassigned by IRS/IRB. Payers who are aware that their TCC will no longer be used are requested to notify IRS/IRB so these numbers may be reassigned.
- (b) The payer's files were transmitted in the past by a service bureau using the service bureau's TCC, but now the payer has computer equipment compatible with that of IRS/IRB and wishes to prepare his or her own files. The payer must request a TCC by filing Form 4419.

.06 If **any** of the information (name, TIN or address) on Form 4419 changes, please notify IRS/IRB in writing so the IRS/IRB database can be updated. The transmitter should include the TCC in all correspondence.

.07 Approval to file does not imply endorsement by IRS/IRB of any computer software or of the quality of tax preparation services provided by a service bureau or software vendor.

Sec. 5. Filing Requirements

.01 The requirements for Federal Contracts are governed by section 6011(e)(2)(A) and section 6050M of the Internal Revenue Code and Regulation section 1.6050M-1. The term Federal Executive Agency means: (1) any Executive Agency (as defined in Section 105 of title 5, United States Code) other than the Government Accountability Office; (2) any military department as defined in section 102 of such title; and (3) the United States Postal Service and the Postal Rate Commission. A Federal Executive Agency that files 250 or more reportable contracts during a one year period, must file Form 8596 on an electronic file for each quarter of that one year period.

.02 The information returns required by this section with respect to contracts of a Federal Executive Agency entered into on or after January 1, 1989, must be filed on a quarterly basis for the calendar quarters ending on the last day of March, June, September, and December, on or before the last day of the month following that quarter for which the returns are being made.

.03 The information returns required by this section may be made in one submission or in multiple submissions.

.04 If a Federal Executive Agency has reasonable expectations to enter into fewer than 250 reportable contracts during a one year period, the agency may file paper Forms 8596 and 8596-A to: Department of the Treasury, Internal Revenue Service Center, Kansas City, MO 64999-2222.

.05 Election to have the Director of the Federal Procurement Data Center file returns on behalf of an agency. Except for the U.S. Postal Service and the Postal Rate Commission, a Federal Executive Agency may elect to have the Director of the Federal Procurement Data Center (FPDC) file the required returns with IRS on behalf of the agency. The agency must comply with the requirements of the Federal Procurement Data System (FPDS) in submitting the information and must not file with the Internal Revenue Service.

.06 In order to make this election, the head of a Federal Executive Agency (or his or her delegate) shall attach a signed statement to its submission to the FPDC for that quarter stating the following:

- (a) The Director of the FPDC (or his or her delegate) is authorized to submit the required returns on behalf of the agency for contracts for that quarter in accordance with an election under 26 CFR, section 1.6050M-1(d)(5).
- (b) Under the penalties of perjury, the official has examined the information submitted by the agency to the FPDC for use in making returns to be submitted to the IRS and the official certifies that information to be, to the best of his or her knowledge and belief, an accurate compilation of agency records maintained in the normal course of business for the purpose of making true, correct, and complete returns as required by section 6050M.

.07 An agency that elects to have the FPDC file its returns must not submit those same returns to the IRS.

.08 If a contract is increased by more than \$25,000.00 under one action, the action should be treated as a new contract and reported to IRS for the calendar quarter in which the increase occurs. This could occur through the exercise of an option contained in a basic or initial contract or under any other rule of contract law, expressed or implied, when the amount of money or other property obligated under the contract is increased by \$25,000.00.

.09 Special rules to filing requirements are as follows:

- (a) If a subcontract is entered into by the Small Business Administration (SBA) under a prime contract between SBA and a procuring Federal agency pursuant to section 8(a) of the Small Business Act, the procuring agency, not the SBA, will be required to file Forms 8596 and 8596-A.
- (b) A Federal Supply Schedule Contract or an Automated Data Processing Schedule Contract entered into by the General Services Administration (GSA), or a scheduled contract entered into by the Department of Veterans Affairs (VA) on behalf of one or more Federal Executive Agencies, is not to be reported by the GSA or VA at the time of execution. When a Federal Executive Agency, including the GSA or the VA, places an order under a schedule contract, the Federal Executive Agency must file Forms 8596 and 8596-A.

.10 Exceptions: The following are not required to be reported under section 6050M:

- (a) Any contract action of \$25,000.00 or less;
- (b) Any contract which provides that all amounts payable under the contract by a Federal Executive Agency will be paid on or before the 120th day following the date of the contract action and for which it is reasonable to expect that all amounts will be so paid;
- (c) A license granted by a Federal Executive Agency;
- (d) An obligation of a contractor (other than a Federal Executive Agency) to a subcontractor;
- (e) Debt instruments of the U.S. Government or a Federal agency, such as Treasury Notes, Treasury Bonds, Treasury Bills, U.S. Savings Bonds, or similar instruments;
- (f) An obligation of a Federal Executive Agency to lend money, lease property to someone, or sell property;
- (g) A blanket purchase agreement. However, when an order is placed under a blanket purchase agreement, a contract then exists and Forms 8596 and 8596-A must be filed;
- (h) Any contract with a contractor who, in making the agreement, is acting in his or her capacity as an employee of a Federal Executive Agency (*e.g.*, any contract of employment under which the employee is paid wages subject to Federal income tax withholding);
- (i) Any contract between a Federal Executive Agency and another Federal Governmental unit or any subsidiary agency;
- (j) Any contract with a foreign government or agency or any subsidiary agency;
- (k) Any contract with a state or local government or agency or any subsidiary agency;
- (l) Any contract with a person who is not required to have a Taxpayer Identification Number (TIN), such as a nonresident alien, foreign corporation or foreign partnership, any of which does not have income effectively connected with the conduct of a trade or business in the United States and does not have an office or place of business as a fiscal or paying agent in the United States;
- (m) Certain confidential or classified contracts that meet the requirements of section 6050M(e);

- (n) Any contract that provides that all payments made after the 120th day after the date of the contract action will be made by someone other than a Federal Executive Agency or an agent of such an agency. For example, a contract under which the contractor will collect amounts owed to a Federal Executive Agency for the agency's debtor and will remit to the Federal Executive Agency the money collected less an amount for the contractor's consideration under the contract;

- (o) Contracts entered into using nonappropriated funds.

.11 All paper Forms 8596 and 8596-A for both original and corrected returns should be filed with the (Department of Treasury) IRS, Kansas City, MO 64999-2222. Forms 8596 and 8596-A may be obtained by calling 1-800-TAX-FORM (1-800-829-3676).

Sec. 6. Filing of Information Returns For Federal Contracts

.01 Paper information returns must be sent to the IRS Kansas City Service Center using Form 8596 and Form 8596-A. **Returns filed on paper forms must not be sent to the IRS/IRB.**

.02 If a Federal Executive Agency elects to have the FPDC make returns on its behalf, the FPDC shall mail or fax a copy of that agency's signed statement, making the election, to IRS/IRB for that agency for that quarter (See Part A, Sec. 3).

.03 **The transmitter must not report the same information on paper forms that is reported electronically.** If parts of the returns are reported on paper and part electronically, the transmitter must be sure that duplicate information is not included on both. This does not mean that corrected documents should not be filed. If a return has been prepared and submitted improperly, a corrected return must be filed as soon as possible. See Part A, Sec. 8 for requirements and instructions on filing corrected returns.

.04 Agencies are required to retain a copy of the information returns filed with IRS for at least three years or have the ability to reconstruct the data.

Sec. 7. Filing Dates

.01 The information returns required by this section must be filed on a quarterly basis for the calendar quarters as follows:

<u>QUARTER</u>	<u>DUE DATE</u>
January, February, March	April 30
April, May, June	July 31
July, August, September	October 31
October, November, December	January 31

.02 The director of the FPDC (or his or her delegate) shall submit the required return quarterly to IRS on or before the earlier date of:

- (a) 45 days following the date that the contract information is required to be submitted to the FPDC, or
- (b) 90 days following the end of the calendar quarter for which the election is made, except that, if the calendar quarter ends September 30, 105 days following the end of that quarter.

.03 If any due date falls on a Saturday, Sunday or legal holiday, the filing deadline is extended to the next day that is not a Saturday, Sunday, or legal holiday.

Sec. 8. How to File Corrected Returns

- A **correction** is an information return submitted by the transmitter to correct an information return that was previously submitted to and processed by IRS/IRB, but contained erroneous information.
- **DO NOT SEND YOUR ENTIRE FILE AGAIN.** Only send the information returns in need of correction.
- Information returns omitted from the original file **must not** be coded as corrections. Submit them under a separate Payer "A" Record as original returns.
- Before creating your correction file, review the following guidelines chart carefully.

.01 When corrections are necessary, they must be filed in the next filing quarter. If the entire file submitted electronically was in error, the IRS/IRB should be contacted immediately (See Part A, Sec. 3 for the address).

.02 Corrections should be filed **as soon as possible**. All fields must be completed with the correct information, not just the data fields needing correction. Submit corrections only for the returns filed in error, not the entire file. Furnish corrected statements to recipients as soon as possible.

Note: Do NOT resubmit your entire file as corrections. This will result in duplicate filing and erroneous notices may be sent to payees. Submit only those returns which need to be corrected.

.03 There are numerous types of errors, and in some cases, more than one transaction may be required to correct the initial error. If the original return was filed as an aggregate, the filers must consider this in filing corrected returns.

.04 Corrected returns may be included on the same file as original returns; however, separate “A” Records are required. If filers discover that certain information returns were omitted on their original file, they must not code these documents as corrections. The file must be coded and submitted as originals.

.05 Review the chart that follows. Errors normally fall under one of the two categories listed. Next to each type of error is a list of instructions on how to file the corrected return.

Guidelines for Filing Corrected Returns Electronically

Error Made on the Original Return	How To File the Corrected Return
One transaction is required to make the following corrections properly. (See Note.)	
<u>ERROR TYPE 1</u>	<u>CORRECTION</u>
1. Original return was filed with one or more of the following errors: (a) Incorrect dollar amount in the Payee “B” Record (b) Incorrect payee address	A. Prepare a new file. The first record on the file will be the Transmitter “T” Record. B. Make a separate “A” Record for each payer being reported. The information in the “A” Record will be exactly the same as it was in the original submission. C. The Payee “B” Records must show the correct record information as well as a Corrected Return Indicator Code of “G” in Field Position 6. D. Corrected returns submitted to IRS/IRB using “G” coded “B” Records may be on the same file as those returns submitted without the “G” coded “B” Records; however, separate “A” Records are required. E. Prepare a separate “C” Record for each payer being reported. F. The last record on the file will be the End of Transmission “F” Record.

File layout **one** step corrections

Transmitter “T” Record	Payer “A” Record	“G” coded Payee “B” Record	“G” coded Payee “B” Record	End of Payer “C” Record	End of Transmission “F” Record
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Guidelines for Filing Corrected Returns Electronically

Error Made on the Original Return

How To File the Corrected Return

Two (2) separate transactions are required to make the following corrections properly. Follow the directions for both Transactions 1 and 2. DO NOT use the two step correction process to correct money amounts.

ERROR TYPE 2

1. Original return was filed with one or more of the following errors:

- (a) No payee TIN (SSN, EIN, ITIN)
- (b) Incorrect payee TIN
- (c) Incorrect payee name

CORRECTION

Transaction 1: Identify incorrect returns.

- A. Prepare a new file. The first record on the file will be the Transmitter "T" Record.
- B. Make a separate "A" Record for each type of return and each payer being reported. The information in the "A" Record will be **exactly** the same as it was in the original submission.
- C. The Payee "B" Records must contain **exactly the same** information as submitted previously, **except**, insert a Corrected Return Indicator Code of "G" in Field Position 6 of the "B" Records, and enter "0" (zeros) in all payment amounts.
- D. Corrected returns submitted to IRS/IRB using "G" coded "B" Records may be on the same file as those returns submitted with a "C" code; **however, separate "A" Records are required.**
- E. Prepare a separate "C" Record for each type of return and each payer being reported.
- F. Continue with Transaction 2 to complete the correction.

Transaction 2: Report the correct information.

- A. Make a separate "A" Record for each type of return and each payer being reported.
 - B. The Payee "B" Records must show the correct information as well as a Corrected Return Indicator Code of "C" in Field Position 6.
 - C. Corrected returns submitted to IRS/IRB using "C" coded "B" Records may be on the same file as those returns submitted with "G" codes; **however, separate "A" Records are required.**
 - D. Prepare a separate "C" Record for each type of return and each payer being reported.
 - E. The last record on the file will be the End of Transmission "F" Record.
-

File layout **two** step corrections

Transmitter "T" Record	Payer "A" Record	"G" coded Payee "B" Record	"G" coded Payee "B" Record	End of Payer "C" Record	Payer "A" Record
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“C” coded Payee “B” Record	“C” coded Payee “B” Record	End of Payer “C” Record	End of Transmission “F” Record
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Note : If a filer is correcting the name and/or TIN in addition to any errors listed in item 2 of the chart, two transactions will be required. If a filer is reporting “G” coded, “C” coded and/or “Non-coded” (original) returns on the same file, each category must be reported under separate “A” Records.

Sec. 9. Taxpayer Identification Numbers

.01 Contractors are required to furnish Taxpayer Identification Numbers (TINs) to the agency under section 6109 of the Internal Revenue Code.

.02 The contractor’s TIN and name combination is used to associate information returns reported to IRS with corresponding information on tax returns. It is imperative that **correct** social security number (SSN) or employer identification number (EIN) for contractors be provided to IRS. **Do not enter hyphens or alpha characters.** Entering all zeros, ones, twos, etc., will have the effect of an incorrect TIN.

.03 IRS validates the SSN by using the Name Control of the surname of the individual who has been assigned this number. For this reason, the surname should be provided in the Payee Name Line and/or the Name Control in positions 7–10 of the Payee “B” Record. It is imperative to provide correct information for IRS to validate the SSN. IRS validates an EIN by using the name control of the business to which the EIN has been assigned. If an EIN is reported for a contractor, the correct business name should be provided in the First Payee Name Line and/or Name Control in positions 7–10 of the Payee “B” Record.

.04 For sole proprietors, the owner’s name (not the doing business as (DBA) name) must appear in the Payee Name Line. The TIN for a sole proprietor may be either an EIN or SSN.

.05 The TIN to be furnished to IRS depends primarily upon the manner in which the account is maintained or set up on the agency’s record. The payer and payee names and TINs should be consistent with the names and numbers used on other tax returns. The TIN must be that of the contractor. If the contract is recorded in more than one name, the transmitter must furnish the TIN and name of one of the contractors. The TIN provided must be associated with the name of the contractor provided in the First Payee Name Line of the Payee “B” Record.

Sec. 10. State Abbreviations

.01 The following state and U.S. territory abbreviations are to be used when developing the state code portion of address fields.

State	Code	State	Code	State	Code
Alabama	AL	Kentucky	KY	No. Mariana Islands	MP
Alaska	AK	Louisiana	LA	Ohio	OH
American Samoa	AS	Maine	ME	Oklahoma	OK
Arizona	AZ	Marshall Islands	MH	Oregon	OR
Arkansas	AR	Maryland	MD	Pennsylvania	PA
California	CA	Massachusetts	MA	Puerto Rico	PR
Colorado	CO	Michigan	MI	Rhode Island	RI
Connecticut	CT	Minnesota	MN	South Carolina	SC
Delaware	DE	Mississippi	MS	South Dakota	SD
District of Columbia	DC	Missouri	MO	Tennessee	TN
Federated States of Micronesia	FM	Montana	MT	Texas	TX
Florida	FL	Nebraska	NE	Utah	UT
Georgia	GA	Nevada	NV	Vermont	VT
Guam	GU	New Hampshire	NH	Virginia	VA
Hawaii	HI	New Jersey	NJ	U.S. Virgin Islands	VI
Idaho	ID	New Mexico	NM	Washington	WA
Illinois	IL	New York	NY	West Virginia	WV

State	Code	State	Code	State	Code
Indiana	IN	North Carolina	NC	Wisconsin	WI
Iowa	IA	North Dakota	ND	Wyoming	WY
Kansas	KS				

.02 Filers must adhere to the city, state, and ZIP Code format for U.S. addresses in the “B” Record. This also includes American Samoa, Federated States of Micronesia, Guam, Marshall Islands, Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands.

.03 For foreign country addresses, filers may use a 51 position free format which should include city, province or state, postal code, and name of country in this order. This is allowable only if a “1” (one) appears in the Foreign Country Indicator, Field Position 247 of the “B” Record.

.04 When reporting APO/FPO addresses use the following format:

EXAMPLE:

Payee Name	PVT Willard J. Doe
Mailing Address	Company F, PSC Box 100 167 Infantry REGT
Payee City	APO (or FPO)
Payee State	AE, AA, or AP*
Payee ZIP Code	098010100

*AE is the designation for ZIP codes beginning with 090–098, AA for ZIP 340, and AP for ZIP codes 962–966.

Part B. Electronic Filing Specifications

Sec. 1. General

.01 Electronic filing of Form 8596 returns, originals, corrections, and replacements is offered as an alternative to paper filing. There is no minimum of number of forms filing requirement; therefore, any number of forms may be filed electronically. Payers who are under the filing threshold requirement are encouraged to file electronically.

.02 All electronic filing of information returns are received at IRS/IRB via the FIRE (Filing Information Returns Electronically) System. To connect to the FIRE System, point your browser to <http://fire.irs.gov>. The system is designed to support the electronic filing of information returns only.

.03 The electronic filing of information returns is not affiliated with any other IRS electronic filing programs. Filers must obtain separate approval to participate in each of them. Only inquiries concerning electronic filing of information returns should be directed to IRS/IRB.

.04 Files submitted to IRS/IRB electronically must be in standard ASCII code. Do not send paper forms with the same information as electronically submitted files. This would create duplicate reporting resulting in penalty notices.

.05 If a Federal Executive Agency elects to have the FPDC make returns on its behalf, the FPDC shall mail or fax a copy of that agency’s signed statement, making the election, to IRS/IRB (see Part A, Sec. 3).

.06 See Part C, Record Format Specifications and Record Layouts.

Sec. 2. Electronic Filing Approval Procedure

.01 Filers must obtain a Transmitter Control Code (TCC) prior to submitting files electronically. Filers who currently have a TCC may use their assigned TCC for electronic filing. Refer to Part A, Sec. 4, for information on how to obtain a TCC.

.02 Once a TCC is obtained, electronic filers create their own User ID, password and Personal Identification Number (PIN) and do not need prior or special approval. See Part B, Sec. 4, for more information on the PIN.

.03 If a filer is submitting files for more than one TCC, it is not necessary to create a separate logon and password for each TCC.

.04 For all passwords, it is the user’s responsibility to remember the password and not allow the password to be compromised. Passwords are user created at first logon and must be 8 alpha/numerics containing at least 1 uppercase, 1 lowercase, and 1 numeric. However, filers who forget their password or PIN can call **toll-free 1-866-455-7438** for assistance. The FIRE System will require users to change their passwords periodically. Users can change their passwords at any time from the Main Menu. Prior passwords cannot be used.

Sec. 3. Electronic Submissions

.01 Electronically filed information may be submitted to IRS/IRB 24 hours a day, 7 days a week. Technical assistance will be available Monday through Friday between 8:30 a.m. and 4:30 p.m. Eastern time by calling **toll-free at 1-866-455-7438**.

.02 The FIRE System will be down from the last week of December through the first week of January. This allows IRS/IRB to update its system to reflect current year changes. In addition, the FIRE System may be down every Wednesday from 3:00 a.m. to 5:00 a.m. ET for maintenance.

.03 Your file size cannot exceed 2.5 million records. If you are sending files larger than 10,000 records electronically, data compression is encouraged. WinZip and PKZip are the only acceptable compression packages. IRS/IRB cannot accept self-extracting zip files or compressed files containing multiple files. The time required to transmit information returns electronically will vary depending upon the type of connection to the Internet and if data compression is used. **The time required to transmit a file can be reduced by as much as 95 percent by using compression.**

.04 Transmitters may create files using self assigned filename(s). Files submitted electronically will be assigned a new unique file name by the FIRE System. The filename assigned by the FIRE System will consist of submission type (ORIG [original], CORR [correction], and REPL [replacement]), the filer's TCC and a four-digit number sequence. The sequence number will be incremented for every file sent. For example, if it is your first original file for the calendar year and your TCC is 44444, the IRS assigned filename would be ORIG.44444.0001. **Record the filename.** This information will be needed by IRS/IRB to identify the file, if assistance is required.

.05 If a timely submitted file is bad, the filer will have up to 60 days from the day the file was transmitted to submit an acceptable replacement file. If an acceptable replacement file is not received within 60 days, then the payer could be subject to late filing penalties. This only applies to files originally submitted electronically.

.06 The following definitions have been provided to help distinguish between a correction and a replacement:

- A **correction** is an information return submitted by the transmitter to correct an information return that was previously submitted to and successfully processed by IRS/IRB, but contained erroneous information. (See Note.)

Note: Corrections should only be made to records that have been submitted incorrectly, not the entire file.

- A **replacement** is an information return file sent by the filer because the CHECK FILE STATUS option on the FIRE System indicated the original file was bad. After the necessary changes have been made, the file must be transmitted through the FIRE System. (See Note.)

Note: Filers should never transmit anything to IRS/IRB as a "Replacement" file unless the CHECK FILE STATUS option on the FIRE System indicates a previous file is bad.

Sec. 4. PIN Requirements

.01 The user will be prompted to create a PIN consisting of 10 numeric characters when establishing their initial User ID and password.

.02 The PIN is required each time an ORIGINAL, CORRECTION, or REPLACEMENT file is sent electronically and is permission to release the file. An authorized agent may enter their PIN, however, the payer is responsible for the accuracy of the returns. The payer will be liable for penalties for failure to comply with filing requirements. If you forget your PIN, please call **toll-free at 1-866-455-7438** for assistance.

.03 If the file is good, it is released for mainline processing after 10 calendar days from receipt. Contact us **toll-free at 1-866-455-7438** within this 10-day period if there is a reason the file should not be released for further processing. If the file is unacceptable, follow normal replacement procedures.

Sec. 5. Electronic Filing Specifications

.01 The FIRE System is designed exclusively for the filing of Forms 1042-S, 1097, 1098, 1099, 3921, 3922, 5498, 8027, 8596, and W-2G.

.02 A transmitter must have a TCC (see Part A, Sec. 4) before a file can be transmitted.

.03 After 1-2 business days, the results of the electronic transmission will be e-mailed to you providing you supply an accurate e-mail address on the "Verify Your Filing Information" screen. If you are using e-mail filtering software, configure your software to accept e-mail from fire@irs.gov and irs.e-helpmail@irs.gov. If after receiving the e-mail it indicates that your file is bad, you must log into the FIRE system and select CHECK FILE STATUS area to determine what the errors are in your file.

Sec. 6. Connecting to the FIRE System

.01 Before connecting, have your TCC and TIN available.

.02 Filers should turn off pop-up blocking software before transmitting their files.

.03 Your browser must support the security standards listed below.

.04 Your browser must be set to receive "cookies." Cookies are used to preserve your User ID status.

.05 Point your browser to <http://fire.irs.gov> to connect to the FIRE System.

.06 FIRE Internet Security Technical Standards are:

HTTP 1.1 Specification (<http://www.w3.org/Protocols/rfc2616/rfc2616.txt>)

SSL 3.0 or TLS 1.0. SSL and TLS are implemented using SHA and RSA 1024 bits during the asymmetric handshake.

SSL 3.0 Specifications (<http://wp.netscape.com/eng/ssl3>)

TLS 1.0 Specifications (<http://www.ietf.org/rfc/rfc2246.txt>)

The filer can use one of the following encryption algorithms, listed in order of priority, using SSL or TLS:

AES 256-bit (FIPS-197)

AES 128-bit (FIPS-197)

TDES 168-bit (FIPS-46-3)

First time connection to the FIRE System (If you have logged on previously, skip to Subsequent Connections to the FIRE System.)

Click ***“Create New Account”***.

Fill out the registration form and click ***“Submit”***.

Create your ***User ID*** (most users’ logon with their first and last name).

Create and verify your ***password*** (the password is user assigned and must be 8 alpha/numerics, containing at least 1 uppercase, 1 lowercase, and 1 numeric). FIRE will require you to change the password periodically.

Click ***“Create”***.

If you receive the message ***“Account Created”***, click ***“OK”***.

Create and verify your 10-digit self-assigned PIN (Personal Identification Number).

Click ***“Submit”***.

If you receive the message ***“Your PIN has been successfully created!”***, click ***“OK”***.

Read the bulletin(s) and/or ***“Click here to continue”***.

Subsequent connections to the FIRE System

Click ***“Log On”***.

Enter your ***User ID***.

Enter your ***password*** (the password is user assigned and is case sensitive).

Read the bulletin(s) and/or ***“Click here to continue”***.

Uploading your file to the FIRE System

At Menu Options:

Click ***“Send Information Returns”***

Enter your ***TCC***:

Enter your ***TIN***:

Click ***“Submit”***.

The system will then display the company name, address, city, state, ZIP code, telephone number, contact, and e-mail address. This information will be used to e-mail transmitters regarding their transmission. Update as appropriate and/or Click ***“Accept”***.

Note: Please ensure that the e-mail address is accurate so that the correct person receives the e-mail and it does not return to us undeliverable. If you are using SPAM filtering software, please configure it to allow an e-mail from *fire@irs.gov* and *irs.e-helpmail@irs.gov*.

Click one of the following:

Original File

Correction File

Replacement File (Click on the file to be replaced).

- **Electronic Replacement** (bad file was originally transmitted, on FIRE System)
Click the file to be replaced.

Enter your 10-digit PIN.

Click **“Submit”**.

Click **“Browse”** to locate the file and open it.

Click **“Upload”**.

When the upload is complete, the screen will display the total bytes received and tell you the name of the file you just uploaded. Print this page and keep it for your records.

If you have more files to upload for that TCC:

Click **“File Another?”**; otherwise,

Click **“Main Menu”**.

It is your responsibility to check the acceptability of your file; therefore, be sure to check back into the system in 1–2 business days using the CHECK FILE STATUS option.

Checking your FILE STATUS

If the correct e-mail address was provided on the “Verify Your Filing Information” screen when the file was sent, an e-mail will be sent regarding your FILE STATUS. If the results in the e-mail indicate “Good, not Released” and you agree with the “Count of Payees”, then you are finished with this file. If you have any other results, please follow the instructions below.

At the Main Menu:

Click **“Check File Status”**.

Enter your **TCC**:

Enter your **TIN**:

Click **“Search”**.

If “Results” indicate:

“Good, Not Released” and you agree with the “Count of Payees”, you are finished with this file. The file will automatically be released after 10 calendar days unless you contact us within this timeframe.

“Good, Released” — File has been released to our mainline processing.

“Bad” — Click on filename to view error message(s). Correct the errors and timely resubmit the file as a “replacement”.

“Not yet processed” — File has been received, but we do not have results available yet. Please check back in a few days.

Click on the desired file for a detailed report of your transmission.

When you are finished, click on **Main Menu**.

Click **“Log Out”**

Close your Web Browser.

Sec. 7. Common Problems and Questions Associated with Electronic Filing

IRS/IRB encourages filers to verify the format and content of each type of record to ensure the accuracy of the data. This may eliminate the need for IRS/IRB to request replacement files. This may be important for those payers who have either had their files prepared by a service bureau or who have purchased software packages. **Filers who engage a service bureau to transmit their files on their behalf should be careful not to report duplicate data, which may generate penalty notices.** This section lists some of the problems most frequently encountered with electronic files submitted to IRS/IRB. These problems may result in IRS/IRB requesting replacement files.

1. Transmitter does not check the FIRE System to determine file acceptability.

The results of your file transfer are posted to the FIRE System within two business days. If the correct e-mail address was provided on the “Verify Your Filing Information” screen when the file was sent, an e-mail will be sent regarding your FILE STATUS. If the results in the e-mail indicate “Good, not Released” and you agree with the “Count of Payees”, then you are finished with this file. If you have any other results, please follow the instructions in the “Check File Status” option. If the file contains errors, you can get an online listing of the errors. Date received and number of payee records are also displayed. If the file is good, but you do not want the file processed, you must contact IRS/IRB within 10 calendar days from the transmission of your file.

2. SPAM filters are not set to receive e-mail from *fire@irs.gov* and *irs.e-helpmail@irs.gov*.

If you want to receive e-mails concerning your files, processing results, reminders and notices, set your SPAM filter to receive e-mail from ***fire@irs.gov*** and ***irs.e-helpmail@irs.gov***.

3. Incorrect e-mail address provided.

When the “Verify Your Filing Information” screen is displayed, make sure your correct e-mail address is listed. If not, please update with the correct e-mail address.

4. Incorrect file is not replaced timely.

If your file is bad, correct the file and timely resubmit as a replacement.

5. Transmitter compresses several files into one.

Only compress one file at a time. For example, if you have 10 uncompressed files to send, compress each file separately and send 10 separate compressed files.

6. Transmitter sends a file and CHECK FILE STATUS indicates that the file is good, but the transmitter wants to send a replacement or correction file to replace the original/correction/replacement file.

Once a file has been transmitted, you cannot send a replacement file unless CHECK FILE STATUS indicates the file is bad (1–2 business days after file was transmitted). If you do not want us to process the file, you must first contact us **toll-free at 1-866-455-7438** to see if this is a possibility.

7. Transmitter sends an original file that is good, and then sends a correction file for the entire file even though there are only a few changes.

The correction file, containing the proper coding, should only contain the records needing correction, not the entire file.

8. File is formatted as EBCDIC.

All files submitted electronically must be in standard ASCII code.

9. Transmitter has one TCC number, but is filing for multiple companies, which EIN should be used submitting the file?

When sending the file electronically, you will need to enter the EIN of the company assigned to the TCC. When you upload the file, it will contain the TINs for the other companies that you are filing for. This is the information that will be passed forward.

10. Transmitter sent the wrong file, what should be done?

Call us as soon as possible **toll-free at 1-866-455-7438**. We may be able to stop the file before it has been processed. **Please do not send a replacement for a file that is marked as a good file.**

Part C. Record Format Specifications and Record Layouts

Sec. 1. General

.01 The specifications contained in this part of the Revenue Procedure defines the required formation and contents of the records to be included in the electronic files.

.02 A provision is made in the “B” Records for entries which are optional. If the field is not used, enter blanks to maintain a fixed record length of 750 positions. Each field description explains the intended use of specific field positions.

Sec. 2. Transmitter “T” Record — General Field Descriptions

.01 The Transmitter “T” Record identifies the entity transmitting the electronic file and contains information which is critical if it is necessary for IRS/IRB to contact the filer.

.02 The Transmitter “T” Record is the first record on each file and is followed by a Payer “A” Record. A file format diagram is located at the end of Part C. A replacement file will be requested by IRS/IRB if the “T” Record is not present.

.03 For all fields marked “**Required**”, the transmitter must provide the information described under Description and Remarks. For those fields not marked “**Required**”, a transmitter must allow for the field, but may be instructed to enter blanks or zeros in the indicated field positions and for the indicated length.

.04 All records must be a fixed length of 750 positions.

.05 All alpha characters entered in the “T” Record must be upper-case, except e-mail addresses which may be case sensitive. **Do not** use punctuation in the name and address fields.

Record Name: Transmitter “T” Record			
Field Position	Field Title	Length	Description and Remarks
1	Record Type	1	Required. Enter “T”.
2–5	Payment Year	4	Required. Enter the 4-digit year in which the contract is signed.
6	Type of Return	1	Required. Enter “G”.
7–15	Transmitter’s TIN	9	Required. Must be the valid nine-digit number TIN assigned by IRS to the Federal Executive Agency. Do not enter hyphens or alpha characters. Entering all zeros, ones, twos, etc., will have the effect of an incorrect TIN.
16–20	Transmitter Control Code	5	Required. Enter the five-character alpha/numeric Transmitter Control Code (TCC) assigned by IRS/IRB. A TCC must be obtained to file data within this program.
21–29	Blank	9	Enter blanks.
30–69	Transmitter Name	40	Required. Enter the name of the transmitter in the manner in which it is used in normal business. If someone other than the Federal Agency is transmitting data, enter the name of the transmitter. The name of the transmitter must be consistent through the entire file. Left-justify and fill unused positions with blanks.
70–109	Transmitter Name (Continuation)	40	Enter any additional information that may be part of the name. Left-justify information and fill unused positions with blanks.
Note: All the information “Required” in Field Positions 110 thru 280 MUST contain the address information where correspondence relating to problems can be sent.			
110–149	Agency Name	40	Required. Enter the name of the agency to be associated with the address where correspondence should be sent.
150–189	Agency Name (Continuation)	40	Enter any additional information that may be part of the name of the company where correspondence should be sent.
190–229	Agency Mailing Address	40	Required. Enter the mailing address where correspondence should be sent.
230–269	Agency City	40	Required. Enter the city, town, or post office where correspondence should be sent.
270–271	Agency State	2	Required. Enter the valid U.S. Postal Service state abbreviation for states. Refer to the chart of valid state codes in Part A, Sec. 10.
272–280	Agency ZIP Code	9	Required. Enter the valid nine-digit ZIP Code assigned by the U.S. Postal Service. If only the first five digits are known, left-justify information and fill unused positions with blanks.
281–303	Blank	23	Enter blanks.

Record Name: Transmitter "T" Record

Field Position	Field Title	Length	Description and Remarks
304–343	Contact Name	40	Required. Enter the name of the person to be contacted if IRS/IRB encounters problems with the file.
344–358	Contact Phone Number & Extension	15	Required. Enter the telephone number of the person to contact regarding electronic files. Omit extension hyphens. If no extension is available, left-justify information and fill unused positions with blanks. For example, the IRS/IRB Customer Service Section telephone number of 866–455–7438 with an extension of 52345 would be 866455743852345.
359–408	Contact E-mail Address	50	Required if available. Enter the e-mail address of the person to contact regarding electronic files. Left-justify information. If no e-mail address is available, enter blanks.
409–499	Blank	91	Enter blanks.
500–507	Record Sequence Number	8	Required. Enter the number of the record as it appears within your file. The record sequence number for the "T" record will always be "1" (one), since it is the first record on your file and you can have only one "T" record in a file. Each record, thereafter, must be incremented by one in ascending numerical sequence, <i>i.e.</i> , 2, 3, 4, etc. Right-justify numbers with leading zeros in the field. For example, the "T" record sequence number would appear as "00000001" in the field, the first "A" record would be "00000002", the first "B" record, "00000003", the second "B" record, "00000004" and so on until you reach the final record of the file, the "F" record.
508–748	Blank	241	Enter blanks.
749–750	Blank	2	Enter blanks, or carriage return/line feed (CR/LF) characters.

Sec. 3. Transmitter "T" Record — Record Layout

Record Type	Payment Year	Type of Return	Transmitter's TIN	Transmitter Control Code	Blank
1	2–5	6	7–15	16–20	21–29

Transmitter Name	Transmitter Name (Contd.)	Agency Name	Agency Name (Contd.)	Agency Mailing Address
30–69	70–109	110–149	150–189	190–229

Agency City	Agency State	Agency ZIP Code	Blank	Contact Name	Contact Phone Number & Extension	Contact E-mail Address
230–269	270–271	272–280	281–303	304–343	344–358	359–408

Blank	Record Sequence Number	Blank	Blank or CR/LF
409–499	500–507	508–748	749–750

Sec. 4. Payer “A” Record — General Field Descriptions

.01 The Payer “A” Record identifies the agency that made the payments and provides parameters for the succeeding Payee “B” Records. IRS computer programs rely on the absolute relationship between the parameters and data fields in the “A” Record and the data fields in the “B” Record to which they apply.

.02 All records must be a fixed length of 750 positions.

.03 An “A” Record may be blocked with “B” Records; however, the initial record on a file must be a Transmitter “T” Record followed by a Payer “A” Record. IRS/IRB will accept an “A” Record after a “C” Record.

.04 The number of “A” Records appearing on the file will depend on the number of agencies being reported. A separate “A” Record is required for each agency followed by the Payee “B” Records for the agency. Each set of “B” Records is followed by a summary “C” Record. If more than one agency is being reported on a file, an “A” Record may follow a “C” Record (*i.e.*, The “A”, “B”, and “C” Records for one agency may be followed by “A”, “B”, and “C” Records for the next agency, etc.).

.05 All alpha characters entered in the “A” Record must be uppercase.

.06 Do not begin any record at the end of a block and continue the same record into the next block.

.07 For all fields marked “**Required**”, the transmitter must provide the information described under Description and Remarks. For those fields not marked “**Required**”, a transmitter must allow for the field, but may be instructed to enter blanks or zeros in the indicated file position(s) and for the indicated length.

Record Name: Payer “A” Record			
Field Position	Field Title	Length	Description and Remarks
1	Record Type	1	Required. Enter “A”.
2–5	Payment Year	4	Required. Enter the 4-digit year in which the contract is signed.
6–11	Blank	6	Enter blanks.
12–20	Payer’s Taxpayer Identification Number (TIN)	9	Required. Must be the valid nine-digit Taxpayer Identification Number assigned to the Federal Executive Agency. Do not enter blanks, hyphens, or alpha characters. All zeros, ones, twos, etc., will have the effect of an incorrect TIN.
21–24	Payer Name Control	4	Generally, the Name Control is the first four characters of the payer’s name. The word “the” should be disregarded when it is the first word of the name, unless the name contains only two words. This field should be left blank if the name control is not determinable.
25	Blank	1	Enter blank.
26–27	Type of Return	2	Required. Enter “G”. Left-justify, blank fill.
28	Amount Indicator	1	Required. Enter “8”.
29–51	Blank	23	Enter blanks.
52	Foreign Entity Indicator	1	Enter a “1” (one) if the payer is a foreign entity and income is paid by the foreign entity to a U.S. resident. If the payer is not a foreign entity, enter a blank.
53–92	First Payer Name Line	40	Required. Enter the name of the Federal Agency whose TIN appears in positions 12–20 of the “A” Record. The name of the agency must be entered in the manner in which it is used in normal business. Any extraneous information must be deleted. Left-justify information, and fill unused positions with blanks.
93–132	Second Payer Name Line	40	Required. Enter the name and title of the person to whom requests for an offset against any unpaid tax liability of the contractor can be sent. If necessary, please abbreviate.
133	Blank	1	Enter blank.
134–173	Payer Shipping Address	40	Required. Enter the address of the person to whom requests for an offset against any unpaid tax liability of the contract can be sent. The street address should include number, street, apartment or suite number (or P.O. Box if mail is not delivered to a street address). Left-justify and fill with blanks.

Record Name: Payer “A” Record

Field Position	Field Title	Length	Description and Remarks
For U.S. addresses , the payer city, state, and ZIP Code must be reported as 40, 2, and 9 position fields, respectively. Filers must adhere to the correct format for the payer city, state, and ZIP Code.			
For foreign addresses , filers may use the payer city, state, and ZIP Code as a continuous 51 position field. Enter information in the following order: city, province or state, postal code, and the name of the country. When reporting a foreign address, the Foreign Entity Indicator in position 52 must contain a “1” (one).			
174–213	Payer City	40	Required. Enter the city of the person to whom requests for an offset against any unpaid tax liability of the contractor can be sent. Left-justify and fill with blanks.
214–215	Payer State	2	Required. Enter the valid U.S. Postal Service state abbreviations for states. Refer to the chart of valid state abbreviations in Part A, Sec. 10.
216–224	Payer ZIP Code	9	Required. Enter the valid nine-digit ZIP Code assigned by the U.S. Postal Service. If only the first five digits are known, left-justify information and fill the unused positions with blanks.
225–239	Payer’s Phone Number & Extension	15	Enter the payer’s telephone number and extension.
240–499	Blank	260	Enter blanks.
500–507	Record Sequence Number	8	Required. Enter the number of the record as it appears within your file. The record sequence number for the “T” record will always be “1” (one), since it is the first record on your file and you can have only one “T” record in a file. Each record, thereafter, must be incremented by one in ascending numerical sequence, <i>i.e.</i> , 2, 3, 4, etc. Right-justify numbers with leading zeros in the field. For example, the “T” record sequence number would appear as “00000001” in the field, the first “A” record would be “00000002”, the first “B” record, “00000003”, the second “B” record, “00000004” and so on until you reach the final record of the file, the “F” record.
508–748	Blank	241	Enter blanks.
749–750	Blank	2	Enter blanks or carriage return/line feed (CR/LF) characters.

Sec. 5. Payer “A” Record — Record Layout

Record Type	Payment Year	Blank	Payer’s TIN	Payer Name Control	Blank
1	2–5	6–11	12–20	21–24	25

Type of Return	Amount Indicator	Blank	Foreign Entity Indicator	First Payer Name Line
26–27	28	29–51	52	53–92

Second Payer Name Line	Blank	Payer Shipping Address	Payer City	Payer State	Payer ZIP Code	Payer’s Phone & Extension
93–132	133	134–173	174–213	214–215	216–224	225–239

Blank	Record Sequence Number	Blank	Blank or CR/LF
240–499	500–507	508–748	749–750

Sec. 6. Payee “B” Record — General Field Descriptions

.01 The Payee “B” Record contains payment information from the individual contracts.

When filing information documents electronically, the format for the Payee “B” Records will remain constant.

.02 All records must be a fixed length of 750 positions.

.03 The following specifications include a field in the payee records called “Name Control” in which the first four characters of the payee’s surname are to be entered by the filer.

(a) If filers are unable to determine the first four characters of the surname, the Name Control Field may be left blank. Compliance with the following will facilitate IRS computer programs in identifying the correct name control:

- (1) The surname of the payee whose TIN is shown in the “B” Record should always appear first. If, however, the records have been developed using the first name first, the filer must leave a blank space between the first and last names.
- (2) In the case of multiple payees, only the surname of the payee whose TIN (SSN, EIN or ITIN) is shown in the “B” Record must be present in the First Payee Name Line. Surnames of any other payees may be entered in the Second Payee Name Line.

.04 For all fields marked “**Required**”, the transmitter must provide the information described under Description and Remarks. For those fields not marked “**Required**”, the transmitter must allow for the field, but may be instructed to enter blanks or zeros in the indicated field position(s) and for the indicated length.

.05 All alpha characters entered in the “B” Record must be uppercase.

.06 Decimal points (.) cannot be used to indicate dollars and cents.

.07 IRS strongly encourages filers to review data for accuracy before submission to facilitate the collection of delinquent federal tax liabilities from contractors. Filers should be especially careful that names, TINs, and income amounts are correct.

Record Name: Payee “B” Record			
Field Position	Field Title	Length	Description and Remarks
1	Record Type	1	Required. Enter “B.”
2–5	Payment Year	4	Required. Enter the 4-digit year in which the contract is signed.
6	Corrected Return Indicator	1	Required for corrections only. Indicates a corrected return.
(See Note.)		<u>Code</u>	<u>Definition</u>
		G	If this is a one-transaction correction or the first of a two-transaction correction.
		C	If this is the second transaction of a two transaction correction.
		Blank	If this is not a return being submitted to correct information already processed by IRS.

Note: C, G, and non-coded records must be reported using separate Payer “A” Records. Refer to Part A, Sec. 8, for specific instructions on how to file corrected returns.

Record Name: Payee “B” Record

Field Position	Field Title	Length	Description and Remarks
7–10	Name Control	4	If determinable, enter the first four (4) characters of the surname of the person whose TIN is being reported in positions 12–20 of the “B” Record; otherwise, enter blanks. This usually is the contractor. Surnames of less than four (4) characters should be left-justified, filling the unused positions with blanks. Special characters and imbedded blanks should be removed. In the case of a business, other than a sole proprietorship, use the first four significant characters of the business name. Disregard the word “the” when it is the first word of the name, unless there are only two words in the name. A dash (-) and an ampersand (&) are the only acceptable special characters. Surname prefixes are considered part of the surname, <i>e.g.</i> , for Van Elm, the name control would be VANE.

Note: Imbedded blanks, extraneous words, titles, and special characters (*i.e.*, Mr., Mrs., Dr., period [.] , apostrophe [']) should be removed from the Payee Name Lines. This information may be dropped during subsequent processing at IRS/IRB. A dash (-) and an ampersand (&) are the only acceptable special characters.

The following examples may be helpful to filers developing the Name Control.

<u>Name</u>	<u>Name Control</u>
--------------------	----------------------------

Individuals:

Jane Brown	BROW
John A. Lee	LEE*
James P. En , Sr.	EN*
John O’Neil	ONEI
Mary Van Buren	VANB
Juan De Jesus	DEJE
Gloria A. El-Roy	EL-R
Mr. John Smith	SMIT
Joe McCarthy	MCCA
Pedro Torres-Lopes **	TORR
Maria Lopez Moreno**	LOPE
Binh To La	LA*
Nhat Thi Pham	PHAM
Mark D’Allesandro	DALL

Corporations:

The First National Bank	FIRS
The Hideaway	THEH
A&B Cafe	A&BC
11TH Street Inc.	11TH

Sole Proprietor:

Mark Hemlock	HEML
DBA The Sunshine Club	

Partnership:

Robert Aspen	ASPE
and Bess Willow	
Harold Fir , Bruce Elm,	FIR*
and Joyce Spruce et al Ptr	

Record Name: Payee "B" Record

Field Position	Field Title	Length	Description and Remarks															
Estate:																		
	Frank White Estate	WHIT																
	Estate of Sheila Blue	BLUE																
Trusts and Fiduciaries:																		
	Daisy Corporation Employee Benefit Trust	DAIS																
	Trust FBO The Cherry blossom Society	CHER																
Exempt Organizations:																		
	Laborer's Union, AFL-CIO	LABO																
	St. Bernard's Methodist Church Bldg. Fund	STBE																
*Name Controls of less than four (4) significant characters must be left-justified and blank-filled.																		
**For Hispanic names, when two last names are shown for an individual, derive the name control from the first last name.																		
11	Type of TIN	1	This field is used to identify the Taxpayer Identification Number (TIN) in positions 12–20 as either an Employer Identification Number (EIN), a Social Security Number (SSN), or an Individual Taxpayer Identification Number (ITIN). Enter the appropriate code from the following table:															
			<table><tr><th>Code</th><th>Type of TIN</th><th>Type of Account</th></tr><tr><td>1</td><td>EIN</td><td>A business, organization, sole proprietor, or other entity</td></tr><tr><td>2</td><td>SSN</td><td>An individual, including a sole proprietor or</td></tr><tr><td>2</td><td>ITIN</td><td>An individual required to have a taxpayer identification number, but who is not eligible to obtain an SSN</td></tr><tr><td>Blank</td><td>N/A</td><td>If the type of TIN is not determinable, enter a blank.</td></tr></table>	Code	Type of TIN	Type of Account	1	EIN	A business, organization, sole proprietor, or other entity	2	SSN	An individual, including a sole proprietor or	2	ITIN	An individual required to have a taxpayer identification number, but who is not eligible to obtain an SSN	Blank	N/A	If the type of TIN is not determinable, enter a blank.
Code	Type of TIN	Type of Account																
1	EIN	A business, organization, sole proprietor, or other entity																
2	SSN	An individual, including a sole proprietor or																
2	ITIN	An individual required to have a taxpayer identification number, but who is not eligible to obtain an SSN																
Blank	N/A	If the type of TIN is not determinable, enter a blank.																
12–20	Contractor's Taxpayer Identification Number (TIN)	9	Required. Enter the nine-digit Taxpayer Identification Number of the contractor (SSN, ITIN, or EIN). If an identification number has been applied for but not received, enter blanks. Do not enter hyphens or alpha characters. All zeros, ones, twos, etc., will have the effect of an incorrect TIN. If the TIN is not available, enter blanks.															
21–29	Common Parent's Taxpayer Identification Number (TIN)	9	Required. If applicable, enter the valid nine-digit number assigned to the contractor's common parent; otherwise, enter blanks. Do not enter hyphens or alpha characters. All zeros, ones, twos, etc., will have the effect of an incorrect TIN.															
30–54	Blank	25	Enter blanks.															
55–138	Zero	84	Required. Enter zeros.															
139–150	Total Amount Obligated Under Contract	12	Required. The amount reported in this field represents Total Amount Obligated Under the Contract. The Under Contract amount must be entered in U.S. dollars and cents. Dollar signs, commas, decimal points, or negative payments are not acceptable. Amount obligated must be right-justified and unused positions must be zero filled.															

Record Name: Payee “B” Record

Field Position	Field Title	Length	Description and Remarks
151–198	Zero	48	Required. Enter zeros.
199–246	Blank	48	Enter blanks.
247	Foreign Country Indicator	1	If the address of the payee is in a foreign country, enter a “1” (one) in this field; otherwise, enter blank. When filers use this indicator, they may use a free format for the payee city, state, and ZIP Code. Address information must not appear in the First or Second Payee Name Lines.
248–287	First Payee Name Line	40	Required. Enter the name of the contractor (preferably surname first) whose Taxpayer Identification Number (TIN) was provided in positions 12–20 of the “B” Record. Left-justify and fill unused positions with blanks. If more space is required for the name, utilize the Second Payee Name Line Field. If there are multiple payees, only the name of the payee whose TIN has been provided should be entered in this field. The names of the other payees may be entered in the Second Payee Name Line Field. If reporting information for a sole proprietor, the individual’s name must always be present on the First Payee Name Line. The use of the business name is optional in the Second Payee Name Line Field.
288–327	Second Payee Name Line	40	If there are multiple payees, (<i>e.g.</i> , partners or joint owners), use this field for those names not associated with the TIN provided in positions 12–20 of the “B” Record or if not enough space was provided in the First Payee Name Line, continue the name in this field (See Notes). Do not enter address information. It is important that filers provide as much payee information to IRS/IRB as possible to identify the payee associated with the TIN. Left-justify and fill unused positions with blanks.
Note: End First Payee Name Line with a full word. Do not split words. Begin Second Payee Name Line with the next sequential word.			
If applicable, enter the business name of the sole proprietor in this field.			
328–367	Blank	40	Enter blanks.
368–407	Payee Mailing Address	40	Required. Enter the mailing address of the contractor. The street address should include number, street, apartment or suite number (or P.O. Box if mail is not delivered to street address). Left-justify information and fill unused positions with blanks. This field must not contain any data other than the payee’s mailing address.
For U.S. addresses , the payee city, state, and ZIP Code must be reported as 40, 2, and 9 position fields, respectively. Filers must adhere to the correct format for the payee city, state, and ZIP Code.			
For foreign addresses , filers may use the payee city, state, and ZIP Code as a continuous 51 position field. Enter information in the following order: city, province or state, postal code, and the name of the country. When reporting a foreign address, the Foreign Country Indicator in position 247 must contain a “1” (one).			
408–447	Blank	40	Enter blanks.
448–487	Payee City	40	Required. Enter the city, town, or post office. Left-justify information and fill the unused positions with blanks. Enter APO or FPO if applicable. Do not enter state and ZIP Code information in this field.
488–489	Payee State	2	Required. Enter the valid U.S. Postal Service state abbreviations for states or the appropriate postal identifier (AA, AE, or AP) described in Part A, Sec. 10.

Record Name: Payee "B" Record

Field Position	Field Title	Length	Description and Remarks
490–498	Payee ZIP Code	9	Required. Enter the valid nine-digit ZIP Code assigned by the U.S. Postal Service. If only the first five digits are known, left-justify information and fill the unused positions with blanks. For foreign countries, alpha characters are acceptable as long as the filer has entered a "1" (one) in the Foreign Country Indicator, located in position 247 of the "B" Record.
499	Blank	1	Enter blank.
500–507	Record Sequence Number	8	Required. Enter the number of the record as it appears within your file. The record sequence number for the "T" record will always be "1" (one), since it is the first record on your file and you can have only one "T" record in a file. Each record, thereafter, must be incremented by one in ascending numerical sequence, <i>i.e.</i> , 2, 3, 4, etc. Right-justify numbers with leading zeros in the field. For example, the "T" record sequence number would appear as "00000001" in the field, the first "A" record would be "00000002", the first "B" record, "00000003", the second "B" record, "00000004" and so on until you reach the final record of the file, the "F" record.
508–544	Blank	37	Enter blanks.
545	Filing Quarter	1	Required. Enter quarter; <i>i.e.</i> , 1, 2, 3, or 4. See the chart below to determine the appropriate quarter. <u>Quarter</u> 1 January, February, March 2 April, May, June 3 July, August, September 4 October, November, December
546–553	Blank	8	Enter blanks.
554–568	Contract Number	15	Required (if available). Enter the contract number assigned by the Federal Executive Agency. Left-justify and fill the unused positions with blanks.
569	Blank	1	Enter blank.
570–573	Contract Modification Number	4	Required (if available). Enter the number assigned to the contract or order to designate a modification or termination. If this field is not utilized, enter blanks.
574	Blank	1	Enter blank.
575–589	Contract Office Order Number	15	Required (if available). Enter the number assigned by the contracting office. Left-justify and fill the unused positions with blanks.
590	Blank	1	Enter blank.
591–594	Reporting Agency Code	4	Required. Enter the four-digit agency and sub-agency code.
595	Blank	1	Enter blank.
596–600	Contract Office Number	5	Required (if available). Enter the number assigned by the Federal Executive Agency that identifies the purchasing or contracting office.
601	Blank	1	Enter blank.
602–609	Date of Contract Action	8	Required. Enter the date of the action. Use YYYYMMDD (<i>e.g.</i> , 20080214).

Record Name: Payee "B" Record

Field Position	Field Title	Length	Description and Remarks
610	Blank	1	Enter blank.
611–618	Contract Completion Date	8	Required. Enter the expected date of completion of contract such as the contract delivery date under the contract schedule. Use YYYYMMDD. If completion date is not available, enter blanks.
619–658	Name of Common Parent	40	Required (if applicable). If the contractor is a member of an affiliated group of corporations that files its income tax returns on a consolidated basis, enter the name of the common parent of the affiliated group. The name entered should match the EIN in positions 21–29. If this field is not utilized, enter blanks.
659–748	Blank	90	Enter blanks.
749–750	Blank	2	Enter blanks or carriage return line feed (CR/LF) characters.

Sec. 7. Payee "B" Record — Record Layout

Record Type	Payment Year	Corrected Return Indicator	Name Control	Type of TIN	Contractor's Taxpayer Identification Number (TIN)
1	2–5	6	7–10	11	12–20

Common Parent's Taxpayer Identification Number (TIN)	Blank	Zero	Total Amount Obligated Under Contract	Zero	Blank	Foreign Country Indicator
21–29	30–54	55–138	139–150	151–198	199–246	247

First Payee Name Line	Second Payee Name Line	Blank	Payee Mailing Address	Blank	Payee City	Payee State	Payee ZIP Code
248–287	288–327	328–367	368–407	408–447	448–487	488–489	490–498

Blank	Record Sequence Number	Blank	Filing Quarter	Blank	Contract Number	Blank	Contract Modification Number
499	500–507	508–544	545	546–553	554–568	569	570–573

Blank	Contract Office Order Number	Blank	Reporting Agency Code	Blank	Contract Office Number	Blank
574	575–589	590	591–594	595	596–600	601

Date of Contract Action	Blank	Contract Completion Date	Name of Common Parent	Blank	Blank or CR/LF
602–609	610	611–618	619–658	659–748	749–750

Sec. 8. End of Payer “C” Record — General Field Descriptions and Record Layout

.01 The End of Payer “C” Record is a fixed record length of 750 positions.

.02 The control total field is 18 positions in length.

.03 The End of Payer “C” Record is a summary record for a given payer.

.04 The “C” Record will contain the total number of payees and total of the payment amounts of a given payer. The “C” Record must be written after the last Payee “B” Record for a given payer. For each “A” Record and group of “B” Records on the file, there must be a corresponding “C” Record.

.05 Payers/Transmitters should verify the accuracy of the totals since data with missing or incorrect “C” Records will require a replacement.

Record Name: End of Payer “C” Record

Field Position	Field Title	Length	Description and Remarks
1	Record Type	1	Required. Enter “C”.
2–9	Number of Payees	8	Required. Enter the total number of “B” Records covered by the preceding “A” Record. Right-justify information and fill unused positions with zeros.
10–15	Blank	6	Enter blanks.
16–141	Zero	126	Enter zeros
142–159	Control Total	18	Required. Enter the total amount paid to contractors for all contracts present in the preceding Payee “B” Records. The Control Total must be entered in U.S. dollars and cents . Dollar signs, commas, decimal points, or negative payments are not acceptable. Total must be right-justified and unused positions must be zero filled.
160–231	Zero	72	Enter zeros.
232–499	Blank	268	Enter blanks.
500–507	Record Sequence Number	8	Required. Enter the number of the record as it appears within your file. The record sequence number for the “T” record will always be “1” (one), since it is the first record on your file and you can have only one “T” record in a file. Each record, thereafter, must be incremented by one in ascending numerical sequence, <i>i.e.</i> , 2, 3, 4, etc. Right-justify numbers with leading zeros in the field. For example, the “T” record sequence number would appear as “00000001” in the field, the first “A” record would be “00000002”, the first “B” record, “00000003”, the second “B” record, “00000004” and so on until you reach the final record of the file, the “F” record.
508–748	Blank	241	Enter Blanks.
749–750	Blank	2	Enter blanks, or carriage return/line feed (CR/LF) characters.

End of Payer “C” Record — Record Layout

Record Type	Number of Payees	Blank	Zero	Control Total	Zero
1	2–9	10–15	16–141	142–159	160–231

Blank	Record Sequence Number	Blank	Blank or CR/LF
232–499	500–507	508–748	749–750

Sec. 9. End of Transmission “F” Record — General Field Descriptions and Record Layout

.01 The End of Transmission “F” record is a fixed record length of 750 positions.

.02 The “F” Record is a summary of the number of payers in the entire file.

.03 This record should be written after the last “C” Record of the entire file.

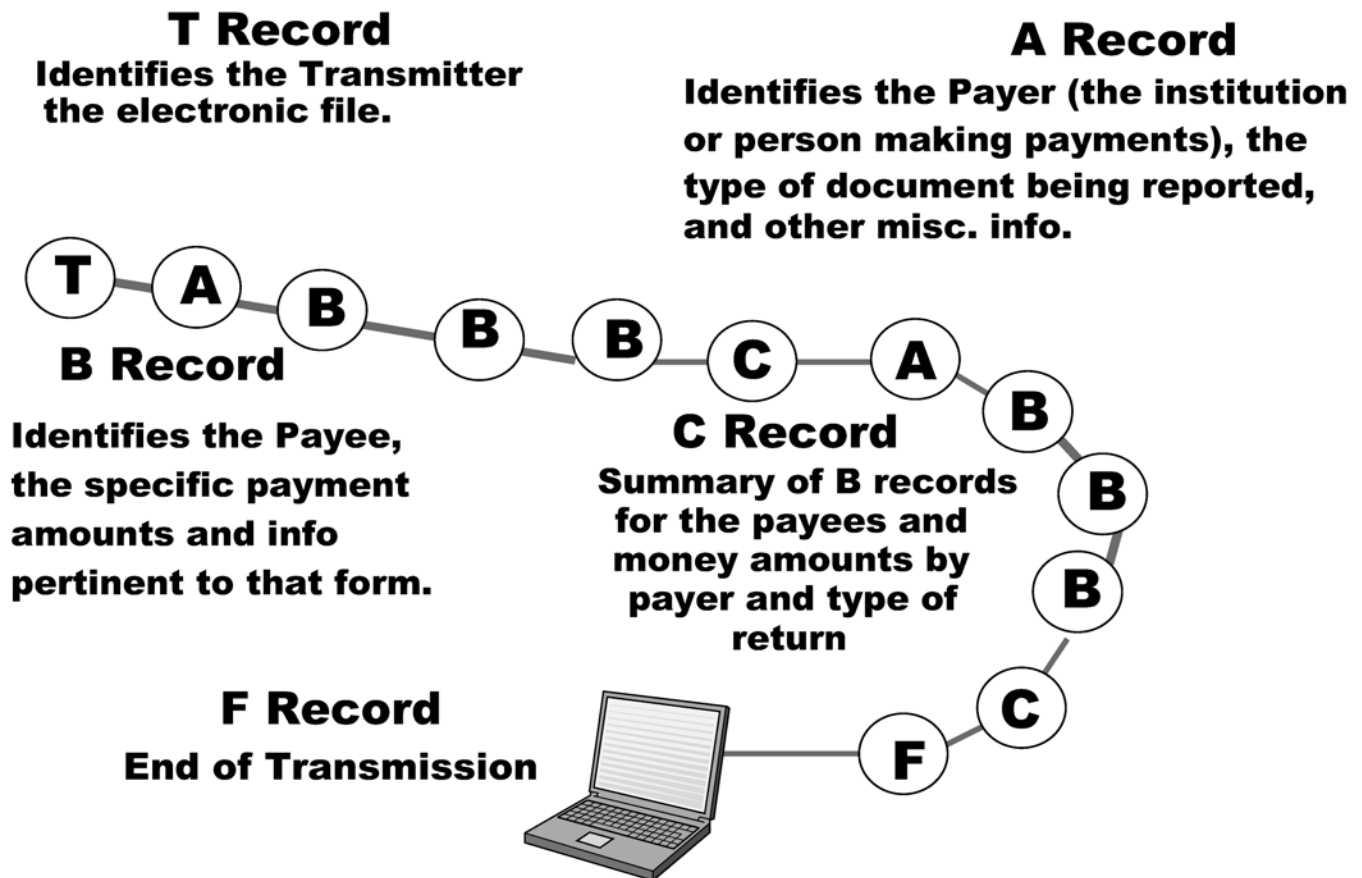
Record Name: End of Transmission “F” Record			
Field Position	Field Title	Length	Description and Remarks
1	Record Type	1	Required. Enter “F.”
2–9	Number of “A” Records	8	Enter the total number of Payer “A” Records in the entire file (right-justify and zero fill).
10–30	Zero	21	Enter zeros.
31–499	Blank	469	Enter blanks.
500–507	Record Sequence Number	8	Required. Enter the number of the record as it appears within your file. The record sequence number for the “T” record will always be “1” (one), since it is the first record on your file and you can have only one “T” record in a file. Each record, thereafter, must be incremented by one in ascending numerical sequence, <i>i.e.</i> , 2, 3, 4, etc. Right-justify numbers with leading zeros in the field. For example, the “T” record sequence number would appear as “00000001” in the field, the first “A” record would be “00000002”, the first “B” record, “00000003”, the second “B” record, “00000004” and so on until you reach the final record of the file, the “F” record.
508–748	Blank	241	Enter blanks.
749–750	Blank	2	Enter blanks or carriage return/line feed (CR/LF) characters.

End of Transmission “F” Record — Record Layout

Record Type	Number of “A” Records	Zero	Blank	Record Sequence Number	Blank	Blank or CR/LF
1	2–9	10–30	31–499	500–507	508–748	749–750

Sec. 10. File Record Layout

Each record must be 750 positions.



Part IV. Items of General Interest

Notice of Proposed Rulemaking by Cross-Reference to Temporary Regulations

Requirements for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes under the Patient Protection and Affordable Care Act

REG-125592-10

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice of proposed rulemaking by cross-reference to temporary regulations.

SUMMARY: Elsewhere in this issue of the Bulletin, the IRS is issuing temporary regulations (T.D. 9494) under the provisions of the Patient Protection and Affordable Care Act (the Affordable Care Act) regarding internal claims and appeals and external review processes. The IRS is issuing the temporary regulations at the same time that the Employee Benefits Security Administration of the U.S. Department of Labor and the Office of Consumer Information and Insurance Oversight of the U.S. Department of Health and Human Services are issuing substantially similar interim final regulations with respect to group health plans and health insurance coverage offered in connection with a group health plan under the Employee Retirement Income Security Act of 1974 and the Public Health Service Act. The temporary regulations provide guidance to employers, group health plans, and health insurance issuers providing group health insurance coverage. The text of those temporary regulations also serves as the text of these proposed regulations.

DATES: Written or electronic comments and requests for a public hearing must be received by October 21, 2010.

ADDRESSES: Send submissions to: CC:PA:LPD:PR (REG-125592-10), room 5205, Internal Revenue Service, P.O. Box 7604, Ben Franklin Station, Washington, DC 20044. Submissions may be hand-delivered to: CC:PA:LPD:PR (REG-125592-10), Courier's Desk, Internal Revenue Service, 1111 Constitution Avenue, NW, Washington DC 20224. Alternatively, taxpayers may submit comments electronically via the Federal eRulemaking Portal at <http://www.regulations.gov> (IRS REG-125592-10).

FOR FURTHER INFORMATION CONTACT: Concerning the regulations, Karen Levin at 202-622-6080; concerning submissions of comments, Oluwafunmilayo Taylor at 202-622-7180 (not toll-free numbers).

SUPPLEMENTARY INFORMATION:

Background and Explanation of Provisions

The temporary regulations published elsewhere in this issue of the Bulletin add §54.9815-2719T to the Miscellaneous Excise Tax Regulations. The proposed and temporary regulations are being published as part of a joint rulemaking with the Department of Labor and the Department of Health and Human Services (the joint rulemaking). The text of those temporary regulations also serves as the text of these proposed regulations. The preamble to the temporary regulations explains the temporary regulations and these proposed regulations.

Special Analyses

It has been determined that this notice of proposed rulemaking is not a significant regulatory action as defined in Executive Order 12866. Therefore, a regulatory assessment is not required. It has also been determined that section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to this proposed regulation. It is hereby certified that the collections of information contained in this notice of proposed rulemaking will not have a significant impact on a substantial number of small entities. Accordingly, a reg-

ulatory flexibility analysis under the Regulatory Flexibility Act (5 U.S.C. chapter 6) is not required. Section 54.9815-2719T of the temporary regulations requires both group health insurance issuers and group health plans to establish internal claims and appeals and external review processes for adverse benefit determinations. Those processes require the plan and issuer to disclose evidence relied upon in making an adverse benefit determination, to disclose any new rationale for upholding an adverse benefit determination as part of an internal appeal, to provide notice of an adverse benefit determination and of a final internal adverse benefit determination, and to disclose the right to an external review. Under the temporary regulations, if a health insurance issuer satisfies the obligations to have effective internal claims and appeals and external review processes (including these information collection requirements that are an inherent part of those processes), those obligations are satisfied not just for the issuer but also for the group health plan. For group health plans maintained by small entities, it is anticipated that the health insurance issuer will satisfy those obligations to have effective internal claims and appeals and external review processes (including these information collection requirements that are an inherent part of those processes) for both the plan and the issuer in almost all cases. For this reason, these information collection requirements will not impose a significant impact on a substantial number of small entities. Pursuant to section 7805(f) of the Internal Revenue Code, this regulation has been submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on its impact on small business.

Comments and Requests for a Public Hearing

Before these proposed regulations are adopted as final regulations, consideration will be given to any written comments (a signed original and eight (8) copies) or electronic comments that are submitted timely to the IRS. Comments are specifically requested on the clarity of the proposed regulations and how they may be made easier to understand. All comments

will be available for public inspection and copying. A public hearing may be scheduled if requested in writing by a person that timely submits written comments. If a public hearing is scheduled, notice of the date, time, and place for the hearing will be published in the **Federal Register**.

Drafting Information

The principal author of these proposed regulations is Karen Levin, Office of the Division Counsel/Associate Chief Counsel (Tax Exempt and Government Entities), IRS. The proposed regulations, as well as the temporary regulations, have been developed in coordination with personnel from the U.S. Department of Labor and the U.S. Department of Health and Human Services.

* * * * *

Proposed Amendments to the Regulations

Accordingly, 26 CFR part 54 is proposed to be amended as follows:

PART 54—PENSION EXCISE TAXES

Paragraph 1. The authority citation for part 54 is amended by adding an entry in numerical order to read in part as follows:

Authority: 26 U.S.C. 7805 * * *

Section 54.9815-2719 also issued under 26 U.S.C. 9833.

Par. 2. Section 54.9815-2719 is added to read as follows:

§54.9815-2719 Internal claims and appeals and external review processes.

[The text of proposed §54.9815-2719 is the same as the text of paragraphs (a) through (f) of §54.9815-2719T published elsewhere in this issue of the Bulletin].

Steven T. Miller,
*Deputy Commissioner for
Services and Enforcement.*

(Filed by the Office of the Federal Register on July 22, 2010, 8:45 a.m., and published in the issue of the Federal Register for July 23, 2010, F.R. 43109)

Update to all Publications associated with filing information returns through the FIRE (Filing Information Returns Electronically) System

Announcement 2010-87

This announcement affects all filers who use the FIRE System and may wish to submit test files. Effective November 1, 2010, filers who wish to submit electronic test files must now point their browser to <http://fire.test.irs.gov>. This system is designed to support electronic filing tests of information returns only. Electronic filing test dates for Tax Year 2010 are November 1, 2010, through February 15, 2011. If you have questions concerning the announcement, please call toll-free 1-866-455-7438.

Definition of Terms

Revenue rulings and revenue procedures (hereinafter referred to as "rulings") that have an effect on previous rulings use the following defined terms to describe the effect:

Amplified describes a situation where no change is being made in a prior published position, but the prior position is being extended to apply to a variation of the fact situation set forth therein. Thus, if an earlier ruling held that a principle applied to A, and the new ruling holds that the same principle also applies to B, the earlier ruling is amplified. (Compare with *modified*, below).

Clarified is used in those instances where the language in a prior ruling is being made clear because the language has caused, or may cause, some confusion. It is not used where a position in a prior ruling is being changed.

Distinguished describes a situation where a ruling mentions a previously published ruling and points out an essential difference between them.

Modified is used where the substance of a previously published position is being changed. Thus, if a prior ruling held that a principle applied to A but not to B, and the new ruling holds that it applies to both A

and B, the prior ruling is modified because it corrects a published position. (Compare with *amplified* and *clarified*, above).

Obsoleted describes a previously published ruling that is not considered determinative with respect to future transactions. This term is most commonly used in a ruling that lists previously published rulings that are obsoleted because of changes in laws or regulations. A ruling may also be obsoleted because the substance has been included in regulations subsequently adopted.

Revoked describes situations where the position in the previously published ruling is not correct and the correct position is being stated in a new ruling.

Superseded describes a situation where the new ruling does nothing more than restate the substance and situation of a previously published ruling (or rulings). Thus, the term is used to republish under the 1986 Code and regulations the same position published under the 1939 Code and regulations. The term is also used when it is desired to republish in a single ruling a series of situations, names, etc., that were previously published over a period of time in separate rulings. If the new ruling does more than restate the substance

of a prior ruling, a combination of terms is used. For example, *modified* and *superseded* describes a situation where the substance of a previously published ruling is being changed in part and is continued without change in part and it is desired to restate the valid portion of the previously published ruling in a new ruling that is self contained. In this case, the previously published ruling is first modified and then, as modified, is superseded.

Supplemented is used in situations in which a list, such as a list of the names of countries, is published in a ruling and that list is expanded by adding further names in subsequent rulings. After the original ruling has been supplemented several times, a new ruling may be published that includes the list in the original ruling and the additions, and supersedes all prior rulings in the series.

Suspended is used in rare situations to show that the previous published rulings will not be applied pending some future action such as the issuance of new or amended regulations, the outcome of cases in litigation, or the outcome of a Service study.

Abbreviations

The following abbreviations in current use and formerly used will appear in material published in the Bulletin.

A—Individual.
Acq.—Acquiescence.
B—Individual.
BE—Beneficiary.
BK—Bank.
B.T.A.—Board of Tax Appeals.
C—Individual.
C.B.—Cumulative Bulletin.
CFR—Code of Federal Regulations.
CI—City.
COOP—Cooperative.
Ct.D.—Court Decision.
CY—County.
D—Decedent.
DC—Dummy Corporation.
DE—Donee.
Del. Order—Delegation Order.
DISC—Domestic International Sales Corporation.
DR—Donor.
E—Estate.
EE—Employee.
E.O.—Executive Order.

ER—Employer.
ERISA—Employee Retirement Income Security Act.
EX—Executor.
F—Fiduciary.
FC—Foreign Country.
FICA—Federal Insurance Contributions Act.
FISC—Foreign International Sales Company.
FPH—Foreign Personal Holding Company.
FR—Federal Register.
FUTA—Federal Unemployment Tax Act.
FX—Foreign corporation.
G.C.M.—Chief Counsel's Memorandum.
GE—Grantee.
GP—General Partner.
GR—Grantor.
IC—Insurance Company.
I.R.B.—Internal Revenue Bulletin.
LE—Lessee.
LP—Limited Partner.
LR—Lessor.
M—Minor.
Nonacq.—Nonacquiescence.
O—Organization.
P—Parent Corporation.
PHC—Personal Holding Company.
PO—Possession of the U.S.
PR—Partner.

PRS—Partnership.
PTE—Prohibited Transaction Exemption.
Pub. L.—Public Law.
REIT—Real Estate Investment Trust.
Rev. Proc.—Revenue Procedure.
Rev. Rul.—Revenue Ruling.
S—Subsidiary.
S.P.R.—Statement of Procedural Rules.
Stat.—Statutes at Large.
T—Target Corporation.
T.C.—Tax Court.
T.D.—Treasury Decision.
TFE—Transferee.
TFR—Transferor.
T.I.R.—Technical Information Release.
TP—Taxpayer.
TR—Trust.
TT—Trustee.
U.S.C.—United States Code.
X—Corporation.
Y—Corporation.
Z—Corporation.

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Key to Abbreviations:

Ann	Announcement
CD	Court Decision
DO	Delegation Order
EO	Executive Order
PL	Public Law
PTE	Prohibited Transaction Exemption
RP	Revenue Procedure
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SPR	Statement of Procedural Rules
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